

**Service Users' Experiences of  
Liaison Mental Health Care**

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## **DECLARATION**

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## ABSTRACT

Liaison mental health services provide mental health care, including assessment, interventions and sign posting to further specialist care, for those who present with mental health needs in non-mental health settings. Liaison mental health services in the United Kingdom most frequently exist within, but are not limited to general hospital provision. The commissioning of these services is however inconsistent, having developed in an *ad hoc* manner, and the evidence base for an appropriate structure remains limited. This thesis reports an extensive literature review which identifies that to date there has been no published detailed exploration of the experiences of service users of liaison mental health care. Only recently has research been published which tentatively identifies the ability of liaison mental health services to reduce costs to general hospitals of mental health presentations and co-morbidity.

The empirical element of this programme of research is a study of the experiences of service users of a liaison mental health service, offered within a general hospital setting. The service users have experiences of both in-patient and emergency department care. The study utilises a secondary data analysis methodology to provide an in depth interpretation of these experiences. Data were analysed using a grounded theory constant comparative method. A core category of 'negotiating and navigating the system' emerged as service users' experienced psychological distress as they attempted to manage their own resources and expectations as a personal safety net. It is only when this personal strategy fails to alleviate their symptoms that they attempt to find help from professional services within the general hospital. Gaining access to assessment by the liaison mental health service requires the service user to negotiate a complex system of care. This experience is represented in the study utilising a conceptual map of their journey, using the analogy of a road to explore the enablers and barriers to an effective experience of liaison mental health care. A model of liaison mental health care is required that ensures provision of educational support for non-mental health professionals within the general hospital setting. This education needs to acknowledge that those who are having their first experience of a mental health issue often do not know where else to seek help, other than the emergency department, because it represents the 'front door' of health care. The adoption of a comprehensive model of liaison mental health care is a priority for all general hospital settings in order to achieve improved service user experience, cost efficiency and integrated health care provision.



## GLOSSARY OF TERMS

	Explanation
DH	Department of Health. The United Kingdom government department responsible for health care provision.
DSH	Deliberate self-harm also referred to as self-harm, ' <i>self-poisoning or self-injury, irrespective of the apparent purpose of the act</i> ' (NICE, 2004)
ED	Emergency Department. This term has superseded the term Accident and Emergency (A&E). The section of an NHS hospital which is designed to treat patients with acute illness or injury. Patients can present at any time, with a wide range of problems. ED's are open 24 hours a day.
HoNOS	The Health of the Nation Outcome Scales (HoNOS) is a validated scale used to measure risk and vulnerability with individuals with mental health problems in the general population. It provides a systematic summary of behaviours and functioning, is reported as easy to use, provides consistent measurements and provides basic monitoring and outcome information. In addition it allows all staff to work with the same criteria from which to monitor and measure treatment outcomes (Wing et al, 1998; Bebbington et al 1999)
LMH or LMHC	Liaison Mental Health and Liaison Mental Health Care This term has been adopted within the study as a generic term for all mental health activity which occurs within non mental health settings. There are a variety of terms adopted within the published literature including psychiatric liaison, consultation liaison, psychiatric consultation liaison and in some cases psychological medicine, although psychological medicine often represents a more specific aspect of provision. Consultation Liaison and Psychiatric liaison or psychiatric consultation liaison appear to be terms generated from within the medical profession to identify liaison mental health activities. Liaison mental health, for the author, represents an updating of these terms and one which appears to move the activities away from any suggestion that they are activities only undertaken by psychiatrists.
LMHN	Liaison Mental Health Nurse Nurses undertaking the role of assessment, diagnosis, treatment, and discharge of people presenting with mental health issues within non mental health settings.
LMHS	Liaison Mental Health Service Referring to the provision of liaison mental health care
LTC	Long Term Condition A term used primarily in the physical health care arena referring to conditions which can be managed but not cured, for example diabetes and chronic obstructive pulmonary disease.
MUS	Medically unexplained symptoms. Physical symptoms for which insufficient or no underlying physiological reason can be determined. Also referred to as somatoform disorders.
Out of hours	This term is used in relation to Liaison Mental Health Services and denotes presentations to the service which occur outside of the core working hours. The case study liaison mental health service operated core hours of 9am to 9pm week days and 9am to 1pm at weekends during the data collection. Core working hours for liaison mental health services can range from 9-5 Monday to Friday to 24 hour seven days a week. Therefore out of hours can mean different things to different liaison mental health care services.

	<b>Explanation</b>
QIPP	<p>Quality, Innovation, Productivity and Prevention Programme.</p> <p>The Quality, Innovation, Productivity and Prevention programme is a national Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs to make £20bn efficiency savings by 2014/15. The first wave of QIPP focused on Cancer, Diagnostics, Heart, Lung and Stroke.</p> <p><a href="http://www.improvement.nhs.uk/Default.aspx?alias=www.improvement.nhs.uk/qipp">http://www.improvement.nhs.uk/Default.aspx?alias=www.improvement.nhs.uk/qipp</a></p>
PLAN	<p>Psychiatric Liaison Accreditation Network</p> <p>The Psychiatric Liaison Accreditation Network (PLAN) works with services to assure and improve the quality of psychiatric liaison in hospital settings.</p> <p><a href="http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/liaisonpsychiatry/plan.aspx">http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/liaisonpsychiatry/plan.aspx</a></p>
RAID	<p>Rapid Assessment Interface and Discharge. The name of the liaison psychiatry service originating at Birmingham City Hospital. RAID is a specialist multidisciplinary mental health service, now working within all acute hospitals in Birmingham, for people aged over 16. A currently recommended liaison mental health service model.</p> <p><a href="http://www.bsmhft.nhs.uk/our-services/rapid-assessment-interface-and-discharge-raid/">http://www.bsmhft.nhs.uk/our-services/rapid-assessment-interface-and-discharge-raid/</a></p>

## ABBREVIATIONS

A&E:	Accident and Emergency Department
AoMRC:	Academy of Medical Royal Colleges
BJ:	Barbara Johnson
CCG:	Clinical Commissioning Groups
CEM:	College of Emergency Medicine
CPA:	Care Programme Approach
CRD:	Centre for Reviews and Dissemination guidelines
DARE:	Database of Abstracts of Reviews of Effects
DH:	Department of Health
DSH:	Deliberate self-harm
ED:	Emergency department
ESRC:	Economic and Social Research Council
FTN:	Foundation Trust Network
GP:	General Practitioner
HoNOS:	Health of the Nation Outcome Scale
IAPT:	Improving Access to Psychological Therapies
IOM	Institute of Medicine
LMH:	Liaison mental health
LMHC:	Liaison mental health care
LMHN:	Liaison mental health nursing
LMHS:	Liaison mental health services
LTC:	Long-term conditions
JCPMH:	Joint Commissioning Panel for Mental Health
MHA:	Mental Health Act
MUS:	Medically unexplained symptoms
NFA:	No Fixed Abode
NHS:	National Health Service
NICE:	National Institute for Health & Clinical Excellence
PLAN:	Psychiatric Liaison Accreditation Network
QIPP:	Quality, Innovation, Productivity and Prevention
SE:	Sarah Eales
SH:	Sally Hardy
RAID:	Rapid Assessment Interface and Discharge
RCGP:	Royal College of General Practitioners
RCPsych:	Royal College of Psychiatrists
RCT:	Randomised control trial
UK:	United Kingdom
USA:	United States of America
VSSS:	Verona Service Satisfaction Scale



## 1 INTRODUCTION

This study is about the experiences of people who have used liaison mental health services (LMHS) in the United Kingdom (UK). It is important therefore to first offer an introduction to LMHS and the models related to liaison mental health care (LMHC). **The study does not seek to explore the range or evidence base of potential interventions which a LMH professional could chose to utilise for different presentations that service users have when seen by the LMHS. Consideration of interventions for specific mental health presentations adopted within LMHC is beyond the scope of this study.**

LMHS offer mental health assessment, support and care in non-mental health settings; this most commonly takes place in the general or acute hospital setting, although the presence of liaison services in primary care is developing. The people who have shared their experiences for this study have experience of using LMHS as in-patients in the acute hospital and are also experienced as attendees of the emergency department (ED).

A comprehensive explanation of LMHS in acute or general hospitals is provided in a recent commissioning document (Joint Commissioning Panel for Mental Health (JCPMH) (2012) and is reproduced in Figure 1.1 below.



An acute liaison service is designed to provide services for:

- People in acute settings (in-patient or out-patient) who have, or are at risk of, mental disorder.
- People presenting at A&E with urgent mental health care needs.
- People being treated in acute settings with co-morbid physical disorders such as long-term conditions (LTCs) and mental disorder.
- People being treated in acute hospital settings for physical disorders caused by alcohol or substance misuse.
- People whose physical care is causing mental health problems.
- People in acute settings with medically unexplained symptoms (MUS).

The service aims to increase the detection, recognition and early treatment of impaired mental well-being and mental disorder to:

- Reduce excess morbidity and mortality associated with co-morbid mental and physical disorder.
- Reduce excess lengths of stay in acute settings associated with co-morbid mental and physical disorder.
- Reduce risk of harm to the individual and others in the acute hospital by adequate risk assessment and management.
- Reduce overall costs of care by reducing time spent in A&E departments and general hospital beds, and minimising medical investigations and use of medical and surgical out-patient facilities.
- Ensure that care is delivered in the least restrictive and disruptive manner possible.

Joint Commissioning Panel for Mental Health (JCPMH, 2012)

**Figure 1.1: What are Liaison Mental Health Services (JCPMH, 2012)**

## **1.1 Liaison Mental Health Care Models**

Hart (2003) undertook a survey of London Liaison mental health services; of the seventeen services surveyed, models of service delivery ranged from 9am – 5pm Monday to Friday service through to 24 hour 7 days per week services. A variety of extended hours provision, for example services which worked up to 9pm rather than 5pm, were also identified.. Hart (2003) concluded that there existed no recognised standardised approach to liaison service provision. All of the services reported upon had at least one LMH nurse however not all were multi-disciplinary. Where teams were multi-disciplinary they contained varying professional groups, however the primary grouping was nurses and psychiatrists, with some teams including psychologists and social workers. Some services covered all general hospital provision, including the emergency department (ED), whilst others covered in-patient or the ED and again there existed a variety of models in between.

All models of service provision contained direct patient assessment and a level of educational intervention, usually both formally and informally (Roberts, 2002). Hart and Eales (2004) identified competencies required for LMHN including advanced levels of practice in assessment of risk and self-harm, management of complex psychosocial and challenging presentations and ability to offer advice on ethical, legal and capacity issues. At the time the model for liaison mental health consultation (Caplan, 1970) remained a popular model for LMHS,

- Client – Centred Case Consultation

- Direct client assessment, action plan, intervention and referral onwards
- Consultee-Centred Case Consultation
  - Working with the referrer to offer advice on the management of a client and clients who present in future with similar difficulties.
- Program-Centred Administrative Consultation
  - Designing or developing an overall programme to meet a planning or administrative need, e.g. a protocol or algorithm, or designing an effective space in a new ED.
- Consultee-centred administrative consultation
  - Supporting teams to develop skills in areas of mental health care, capacity building.

Roberts (2002) integrated the Caplan (1970) model into his collaborative iteration of LMHC, which included the consultation mode and the direct patient contact aspect of LMHC but also recognized the need for LMH professionals to be involved in research. Furthermore Roberts (2002) also acknowledged the role LMH professionals can play in supervision of other professional groups. The importance of a collaborative approach to LMHC had previously been acknowledged by Tunmore and Thomas (1992) in one of the first UK publications to identify the role of liaison nurses. Tunmore and Thomas (1992) also incorporated both consultation and liaison within their model.

## **1.2 A note about terminology**

Those people who have shared their experiences of LMHC are referred to throughout the document as service users. As with every rule there is an exception, when referring to research of others, for example in the literature review, the term they have chosen is adopted. UK health care is littered with acronyms and abbreviations, therefore in order to remain consistent and transparent a glossary of terms is also provided (pp15).

The service users are referred to by pseudonyms within the document.

## **1.3 Chapter outline**

The thesis is comprised of four main aspects. First the background and rationale for the study are presented in chapter 2; second is a substantive literature review, forming chapter 3, which sets the scene for the study and provides the context. Chapters 4 and 5 provide information about the methodology and the method of conduction, including details of the semi-structured interviews and approach to systematically analysing the interviews. The third main element is in chapter 6, which delivers the findings that emerged from the data analysis of the service user interviews. This is followed by a discussion of the findings and the conclusions drawn, in chapter 7. The final (fourth) substantive section is the recommendations, tackling aspects of policy, practice, education and further research. The author's reflection of progress in meeting some of these within the clinical and academic field is also considered. Each chapter's content is now explained in more depth.

### **1.3.1 *Background and study rationale***

Chapter 2, the study background and rationale, addresses why the study is important and also why it has the potential to offer a unique contribution to the body of knowledge regarding service user experiences. A detailed definition and explanation of LMHC within the general hospital setting is offered. There are many different models of LMHS and the exact nature of the LMHS which the service users have experience is described. The chapter also provides an explanation of the historical development of LMHC within the UK, where the study took place. The involvement and interest of the author in LMHC is also explained and an overview is given of the methodologies used within the study. Chapter 2 makes the case for the relevance and importance of the current study of the experiences of LMHC service users, namely that following an initial review of the literature no previous in depth consideration of the experience of service users of LMHC was evident, either within the UK context, or internationally. The argument is made that this study is a unique and original attempt to obtain an in depth understanding of the experiences of a group of 17 service users with multiple experiences of engaging with LMHC. The chapter concludes by identifying the research aim, objectives and questions.

### **1.3.2 *Substantive literature review***

Chapter 3 is a substantial literature review undertaken in two parts. First, a systematic review of the structure process and outcome of LMHC is presented up to the point of data collection. The policy context at the beginning of the study is explored and there is an exploration of the

prevailing views on the gathering of information from a service user perspective. The second stage of the literature review attempts to bring all of these sections up to date; drawing on the policy changes, developments within the research literature regarding the structure process and outcome of LMHC. Consideration is given to the very limited publications on the experiences of service users of LMHC which have come to light during the study. Changes in the policy context and expert opinion regarding the need for greater incorporation and consideration of service user's views are explored. Literature from related areas of service users attending the ED having self-harmed and those who have made use of another type of crisis service is also presented, which is later compared to the findings of the current study.

Chapter 4 is the methodology chapter and there are two themes to this chapter. First, this study used secondary data, thus appropriateness of the chosen methodology is explained and issues such as consent are considered. The methodology chosen for the analysis of secondary data is also explored, that of the constant comparative method which is an aspect of the grounded theory methodology (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Corbin & Strauss, 2008). Consideration is given to the ontological underpinnings of grounded theory methodology.

Chapter 5 sets out the method for data collection; this necessarily incorporates both information regarding the primary data collection, including

ethical approval, sample selection plus the method of semi-structured interviews utilised for the original data collection. The method chapter then moves to consider the specifics of data analysis used to undertake the secondary data analysis. The constant comparative method is explained and explored, providing an explanation of open and axial coding utilising the paradigm model (Strauss & Corbin, 1990). Constant comparative analysis leading to theory building requires the identification of a core category and the researcher explains how the use of a story line helped to crystallise the core category. Finally chapter 5 concludes with consideration of objectivity, theoretical sensitivity and reflexivity.

### **1.3.3 Study findings**

The thesis then moves on to present the findings in chapter 6. The three axial codes are presented and explained in detail, attempting to draw out the voice of the service user in understanding their perspective of LMHC. The chapter makes use of a jigsaw analogy in order to show how service users are undertaking a difficult journey of discovery and how a successful encounter with the LMHS helps them to piece together a greater understanding of the psychological distress that confronts them and has led them to access the LMHS either, as an in-patient or, via the ED. The potential harm that can occur, as a result of the service user's psychological distress, is an alarming aspect of the service users' narratives and brings into sharp focus the potential value of effective LMHC. The findings draw to a conclusion with the presentation of the emergent core category, bringing together the whole experience of LMHC from the service users' perspective.

The core category is that of 'negotiating and navigating the system'. Service users explained the challenges in accessing services and the experiences that lead to an encounter with the service. Service users also identified the barriers that they are presented with, plus aspects of their experiences that enabled them to complete their journey onwards, through LMHC and aiding them to move forwards in a more positive direction of hope.

Chapter 7 discusses the findings in more detail, linking these to a theoretical construct of hope and its importance in the service user's journey. The importance of a person-centred approach (McCormack & McCance, 2006) to liaising with the service user is identified. Furthermore it is argued that it is not only service users who have need for assistance to 'negotiate and navigate' through in-patient and ED care when they present with psychological distress; but that services are not able to always meet these psychological needs. In order to effect change the logical extension of person-centred care, namely relationship-centred care (Nolan et al, 2004) should, I argue, be at the heart of the work of the LMHS in providing not only direct care to patients (and their personal networks) but also enabling and supporting the work of the staff across the general hospital. It is argued that this will ease the burden currently placed upon the service user to take control of the negotiation and navigation process, thus creating less need to learn 'through bitter experience' how best to present, when to present and what to expect as best outcomes. The chapter also draws on the literature of service users' experiences of crisis mental health care and those of service users attending the ED for episodes of self-harm, in order to further explore



the differences and similarities presented within the findings. As part of a development of the constant comparative analysis the grounded theory method requires a move beyond a simple discussion of the findings towards the presentation of a new theoretical understanding of the service user experience of LMHC. I achieve this through presenting a conceptual map, which attempts to show more vividly how the service users' experience can be represented as a journey; one which begins with a state of hopelessness and potential harm/risk and moves forwards through stages of pre-contact, arrival, assessment and finally into outcomes. This is a challenging journey to navigate and reach the positive destination of hope. In order to aid service users to successfully complete their journey, practitioners can influence this journey through providing effective, person-centred care that further enables the service user to continue onwards, and eventually complete their journey towards a better future.

#### ***1.3.4 Application and author reflections***

Having identified how a positive journey and experience can be achieved and how the journey through LMHS can also be stalled, with a wrong turn taken at any point along the way, the thesis moves into chapter 8 where the recommendations are presented. These recommendations are considered in terms of policy initiatives, practice improvement, further areas of research and the importance of professional targeted education.

The experience of LMHC comes amidst multiple levels of interaction with many healthcare professionals and therefore the recommendations are not

limited to how a LMHS should respond to the findings of the service user experience but also consider what changes, on the part of the wider hospital, could lead to a more appropriate service for those with psychological distress and mental health needs within the general hospital setting.

This study ends in identifying a UK National Health Service (NHS) context of heightened concern about the pressure on spiralling hospital overspend, restricted budgets and the potentially explosive pressures within the ED's of UK hospitals. Yet, it is also a time when mental health has come to the fore in government's focus on public mental health and integrated health and social care policy directives (HM Government, 2011). The findings of this study into the service user experience of mental health care within the general hospital, provide recommendations of how changes to policy could improve the overall experience for service users.

The thesis ends with the author considering how she has continued to take forward the detailed and rich information that service users have given about their experiences of LMHC, and how she has striven to utilise research evidence to effect change; a) at a local level through educational initiatives and b) at a national level through engagement with practice guidelines and national accreditation of LMHS. The recommendations chapter also identifies what research is needed to develop these findings into the next generation of public mental health care service provision, from both the service user experiences and also from evidence from the extensive literature review that has spanned over a decade of on-going reform across public sector services.





## **2 STUDY BACKGROUND AND RATIONALE**

Within this section of the study an overview of LMHC is offered in order to set the scene for the proposed study. The developments within liaison mental health nursing (LMHN) leading up to the study and over the last thirteen years are considered. The UK policy context is included to assist understanding of why and how LMHC and LMHN have developed over time.

An exploration of an historical justification of the proposed study and involvement of the author in the field of LMHC is presented. Identification that there remains a lack of in depth research into the experiences of service users is reported.

The proposed study is based upon the use of a secondary data analysis methodology. The emergence of a growing recognition for the importance of this methodology is described, and an explanation regarding the primary data utilised. There then follows a brief overview of the rationale for the chosen methodology applied to the analysis of the secondary data, which is constant comparative analysis, an aspect of the grounded theory methodology.

### **2.1 What is Liaison Mental Health Care?**

The term liaison mental health care (LMHC) has been adopted within the study as a generic term for all mental health activity which occurs within non mental health settings. There are a variety of terms adopted within the published literature in relation to LMHC including; *psychiatric liaison*, *consultation liaison*, *psychiatric consultation liaison* and in some cases

*psychological medicine*. *Consultation liaison* and *psychiatric liaison* or *psychiatric consultation liaison* appear terms generated from within medical profession terminology to identify liaison mental health activities. *Liaison mental health*, for the author, represents an amalgamation of all these various terms which then allows the definition to move away from any suggestion that *liaison* activities are only undertaken by psychiatrists (Hart et al, 2003).

Schwab (1989) identified the origins of LMHC as far back as the 1700's in the United States of America (USA); whilst Mayou (1990) traced the origins of the UK LMHS to the beginning of the 1900's. Liaison mental health nursing (LMHN) within the USA can be traced back to the 1960's (Robinson, 1982; Roberts, 1997) and in the UK, the first publications related to LMHN began to emerge in the late 1980's with, for example reports of individual LMH nurses operating in the general hospital setting in specific units for oncology and medicine (Jones, 1989; Tunmore 1989). Such liaison services involving nurses have now expanded considerably integrating into all aspects of the general hospital setting, with a most recent focus being upon LMHC centred around the emergency departments.

In its broadest sense Callaghan et al (2003) have defined LMHC as:

*“Services provided by mental health specialists in general health settings whether provided by mental health nurses or psychiatrists alone, or as part of a multidisciplinary team ... characterised by liaison, consultation, education, and in some cases direct intervention with service users.”*

(Callaghan et al, 2003 pp157)

In the above definition by Callaghan et al (2003), consultation can be described as the provision of support and assistance to the patient's clinicians (whether doctors, nurses or allied health professionals) in caring for a patient who exhibits mental health issues, but without direct intervention with the patient on the part of the LMH professional.

## **2.2 The structure of liaison mental health service at the study site**

The focus of this study is adult LMHC within the general hospital setting, provided to all in-patient wards and the emergency department, in the context of a multi-disciplinary LMHS, incorporating psychiatrists, mental health nurses and social workers, within a team offering a 7 days a week, service (9am to 9pm weekdays and 9am to 1pm at weekends)<sup>1</sup>. The study site LMHS was located within an inner city teaching hospital. The LMHS covered the whole hospital, with priority offered to patients attending the Emergency Department (ED). The LMHS at the study site sought to assess patients attending the ED within 1 hour of their being registered attendees, plus aiming to achieve all emergency referrals from in-patient wards within the same time frame. Referrals from in-patient units, not considered an emergency, were to be seen/ assessed within 24 hours.

The ED of the hospital study site represented a standard 'Place of Safety' for the local mental health Trust, under the MHA (1983). This means that

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<sup>1</sup> In January 2002, after data collection, the service became 24 hours 7 days per week.

members of the public who were placed under Section 136 of the Mental Health Act (1983) were conveyed to the ED by the police for assessment.

The service was relatively unique, in the experience of the researcher, because two Approved Social Workers (MHA 1983) were employed within the service. The multi-disciplinary team also contained mental health nurses and psychiatrists at Consultant, Registrar and Senior House officer grade. Liaison nurses were employed at Grade G (at the time of the study) and are now employed at the equivalent Band 7. This represents a senior clinical nursing grade. The LMH nurses were able to admit service users to the mental health trust and discharge service users from the ED and/or the in-patient units, once medical care and treatment was complete. The service operated to the standards set out within the Royal College of Psychiatrists (RCPsych) guidelines on Psychiatric Services to Accident and Emergency Departments (RCPsych, 1996).

### **2.3 The development of liaison mental health care in the UK up to 2003: the rise of liaison mental health nursing and 24 hour provision**

The UK government's white paper, Health of the Nation (Department of Health (DH), 1992) was the first policy paper to identify improving the overall health of the British population. It identified five target areas, one of which was mental illness, setting a target to reduce suicide within the UK. In response, some liaison services focusing on assessment of deliberate self-



harm (DSH) and suicide risk were introduced. The 1994 review of mental health nursing (DH, 1994) acknowledged the existence of mental health nurses in the ED and other general health care settings and recommended research be conducted to examine the potential of liaison nursing to achieving these targets. Mental Health Nursing Addressing Acute Concerns (DH, 1999a) referred to the 1994 recommendations regarding LMH nursing and suggested that LMHS might reduce admissions to in-patient units by finding alternative community-based services. However, this was not taken up by national funding bodies and, as far as the author is aware, no national study of LMHN has to date been completed.

Modernising Mental Health Services Safe, Sound & Supportive (DH, 1998) was the first mental health report that identified the need to provide 24 hour access to mental health services, such as that provided by many ED's. Round the clock access to a skilled mental health assessor was highlighted as central to the concept of safe, sound and supportive services, especially for those presenting to mental health services for the first time. This assessment needed to include 'good risk management'. In Saving Lives Our Healthier Nation (DH, 1999b) suicide was again identified as a key area for improvement. The target in that document was to cut suicide rates by one fifth, by 2010. The document placed the assessment of suicide risk and appropriate follow-up at the centre of plans to reduce suicide rates in the UK. Many suicide and self-harm attempts are seen in the ED, therefore LMHS, where available, carried out many of the assessments in support of the government led suicide reduction targets.

The National Service Framework for Mental Health released in 1999 (DH, 1999c) set seven standards for improving mental health care. Several standards identified the need for quick, 24-hour access to services and this appeared to lead to a resurgence of interest in LMHS. In many areas local mental health NHS Trusts initially planned to meet commitments to 24 hour access with improved provision of ED based LMHS and the provision of emergency clinics, specifically for those with mental health needs.

The Royal College of Psychiatrists (RCPsych) released several reports relating to the provision of LMHS (RCPsych, 1994; Royal College of Physicians & RCPsych, 1995; RCPsych, 1996; Royal College of Surgeons of England & RCPsych 1997). In 1994, the College outlined how those who present to hospital with suicide attempts and DSH should be treated, both by the hospital's medical teams and specialist mental health staff. The report set out guidelines for assessment by medical staff and minimum training standards for specialist assessors. As with the RCPsych report on psychiatric services to Accident and Emergency departments (RCPsych, 1996) this report was not specific about which discipline within a liaison service should complete assessments. The report supported the comprehensive assessment of every self-harm patient seen in A&E or admitted to a hospital ward. The College report for services to A&E was updated in 2004 (RCPsych, 2004), merely reiterating the importance of effective assessment.

Three of the Royal College of Psychiatrists reports (Royal College of Physicians & RCPsych, 1995; RCPsych, 1996 & Royal College of Surgeons of England & RCPsych, 1997) identified the need for multi-disciplinary liaison services to offer support for psychiatric and psychological need to patients in ED's and on in-patient wards of general hospitals.

Developments at the beginning of the 21<sup>st</sup> century in the UK reveal a growing interest in LMHC. For example, with the development of nurse consultant roles in LMHC, these roles were usually allied to well developed and well-resourced LMHS which had at this point developed across the UK, but without the benefit of any national strategy or commitment from the government. At the beginning of this century, attention within the NHS was turning to nationally set standards of practice within the ED. This led Sir George Albertie (the A&E Tsar at that time), to commission a report from the LMH nurse consultants to summarise the status of LMHC within the UK (Hart et al, 2003). In summarising the situation the 2003 report concluded:

*“The practice of Liaison Psychiatry [LMHC] poses the enormous challenge of bridging the gap, both philosophical and practical between the physical – as embodied in the general hospital – and the psychological, as represented by mental health services which still acknowledge little relationship between mind and body. In some respects, liaison psychiatry services are still in their infancy, refining*

*their role and trying to shape their future in an economic and political climate that offers little comfort or recognition of their value.”*

(Hart et al, 2003 pp15)

This Hart et al (2003) quote summarises many of the challenges presented to LMHC and LMHS at this point. Namely, a lack of political engagement with this type of healthcare provision in general hospitals, thus generating a disparate level of service provision across the UK, due perhaps to a lack of policy directive to drive forward and ensure that mental health needs in the general hospital were being accurately recognised and effectively cared for.

#### **2.4 The evolution of LMHC over the course of the current study**

Over the course of this study, in some respects, little has changed in the UK in so much as there remains a lack of political (and therefore national policy engagement) with the provision of LMHC. For example, in 2009 the NHS Confederation released a briefing paper for NHS commissioners reiterating an already stated case for LMHS provision within the general hospital. The paper reminded potential commissioners of the value of LMHS in identifying, assessing and managing the mental health needs of the general hospital population (NHS Confederation, 2009). The briefing paper stated that there were financial benefits to be had from the implementation of LMHS and that service user experiences could be improved with the implementation of LMHC. Whilst there is a good evidence base for the presence of mental health needs in the general hospital population (RCPsych, 2004), as Parsonage et al (2012) identified in 2012, the economic case for LMHS has

yet to be clearly made. Furthermore, Parsonage et al (2012) also identified that there was no research evidence for the evaluation of service users' experiences of LMHS, nor had this been routinely adopted as an outcome measure or aspect of routine audit where LMHS did exist. Therefore, whilst it can be hypothesised that introducing LMHS to the general hospital can lead to improved care of (and therefore the experiences of) LMH service users, this remains an under researched hypothesis. As this study drew towards its closure (2013) the current UK's coalition government has released a new mental health strategy which firmly placed the mental health care of all at the heart of the government agenda (*No health without mental health*. DH, 2011). However, and rather sadly, yet again, in the context of general hospital care, LMHS arguably did not get any recognition; certainly the strategy did not reach the conclusions of Parsonage et al (2012 pp40) that "Every general and acute hospital should have a dedicated in-house liaison psychiatry service".

In 2012 the Royal College of Psychiatrists brought together a working party drawn from all Royal Colleges and related organisations (including the Royal College of Nursing and the College of Emergency Medicine) to amalgamate and update the guidance produced regarding mental health care in acute hospitals, this report is due to be released in 2013 (Butler, 2013).

Regarding LMHN more specifically, as with the previous Department of Health Review of Mental Health Nursing (DH, 1994) LMHN received a passing mention in the Chief Nursing Officers' 2006 report on mental health nursing (DH, 2006) and recognition as an example of good practice. However, this report did not recognise LMHN as a specialist area of practice,

leaving the highly qualified, specialist LMH nurses in a poorly recognised position, yet working within a rapidly growing area of mental health nursing practice.

## **2.5 Evolution of the project: historical justification and study origins**

### ***2.5.1 The researcher's involvement in LMHC research***

In June 2000 the author commenced work as a research assistant on a two year research project: *An evaluation of the liaison mental health service at a London Hospital*. The study was funded by the NHS Research and Development Levy. The study included a clinical audit of the activity of the LMHS, satisfaction surveys of users of the service, non-participant observation, and semi-structured interviews with service users and professional stakeholders of the LMHS about their satisfaction with the service. During this process the research team completed a systematic literature review of the structure, process and outcome of LMHS. The study findings were published in a number of papers (Callaghan et al, 2002; Callaghan et al, 2003; Eales et al, 2006). As part of the study the author completed all of the semi-structured interviews with service users, and was instrumental in completing the literature review, which resulted in publications with collaborating colleagues (Callaghan et al, 2003).

### ***2.5.2 The paucity of research into service user experiences of liaison mental health care up to 2003***

The original literature review (Callaghan et al, 2003) completed in advance of this study process, was unable to identify any previously published

attempts to elicit the satisfaction of service users with LMHS via anything other than satisfaction surveys. Only four studies were identified that used service user satisfaction surveys. Only one study was published (Priami & Plati, 1997), two were local UK reports (Nichols, 1994; Rotherham Priority Health NHS Trust, 2001), and a further Australian report was also considered (Gillette et al, 1996), which continues to be cited in the published Australian literature on LMHC as the key Australian document which covers the service user perspective.

#### *2.5.2.1 Grey literature from Australia on service user experiences of liaison mental health care*

Gillette et al (1996) undertook an evaluation of a pilot psychiatric nurse clinical consultant within the ED of two Melbourne (South Australia) hospitals. As part of the evaluation a client satisfaction survey was undertaken, the survey tool was designed and previously used in the Picker Commonwealth program. The questions were generic in so much as they did not ask about the experience of seeing the psychiatric nurse clinical consultant, rather they consider the ED visit in its entirety, not differentiating between staff providing general care and those from the mental health provision. The participants had attended the service in 1995 and the survey was conducted by telephone, the report did not state who conducted the telephone interviews, however bi-lingual interviewers were used as necessary to ensure that those who were non-English speaking could be included in the process. The consumer satisfaction survey had a before and after element. One half of the sample was recruited prior to a psychiatric

nurse being available in the ED and the other half after the nine month pilot of the service. The psychiatric nurse had a role in direct patient care but also in formal and informal education to the ED staff to improve services to those with mental health issues.

The results from both hospitals were presented together, a total of 75 participants were interviewed before the psychiatric nurse role was implemented and 85 were interviewed after the nine month pilot was introduced. Chi-squared tests were completed to identify significant difference in results before and after; only two aspect of the questionnaire showed significant change, patients waited longer in the after group for treatment, possible reasons for this are not given. Secondly participants were more satisfied with explanations given by nursing staff ( $p < 0.05$ ) in the 'after' group. The report identified trends towards better provision of interpersonal care; for example staff being more aware of clients' feelings and providing emotional support and overall satisfaction also increased, but these trends did not represent statistically significant findings.

#### *2.5.2.2 European published research on service users' experiences of liaison mental health care*

Priami and Plati (1997) undertook a review of consultation liaison nursing interventions with 95 medical and surgical patients in 1990 to 1991. The study took place in Athens, Greece. Patients had been referred to the service primarily for anxiety and depression. Those who had attempted suicide were



excluded, the rationale being their short stay in hospital. At the end of four planned interventions by the consultation liaison nurse the patients were asked to rate their opinion of the intervention using a four point Likert scale. Five questions appear to have been used; the exact wording was not specified. From the results the questions appear to have been about whether verbal expression was facilitated, whether the intervention relieved the psychological condition, whether the physical illness had been relieved, whether the intervention had relieved their physical complaints and finally if the intervention had worsened their psychological condition. Responses were overwhelmingly positive, less than 20% of patients felt only moderate or no impact upon their physical and mental condition; 97.9% identified that the intervention had not worsened their psychological condition. The interventions consisted of verbal psychological support, listening, mental health education and consultation. The nature of consultation as an intervention was not explained. The findings from gathering the opinion of the patients correlated with improvements with their psychological condition. The scale used to assess the patients opinion was not discussed in terms of reliability and validity; however the findings indicated that patients' were helped by the interventions of the consultation liaison nurse.

#### *2.5.2.3 UK grey literature on service users' experiences of liaison mental health care*

Of the two unpublished studies from the UK, one (Nichols, 1994) reported 15 self-report service users' questionnaires, who had self-harmed by overdose at the same hospital as that used for the current study. The study, albeit

small scale, did not report how the questionnaire was tested for reliability or validity. The sample was also very small for a survey design (n=15), as the author themselves notes, drawing conclusions from the findings was difficult. The participants reported the ward based general hospital nurses as the most caring during their stay, other options were the liaison nurse, and psychiatrist. All participants felt that the liaison nurse was able to understand their psychological needs. It is unlikely that this study would have come to the attention of the researcher had it not been conducted in the case study hospital, because it was unpublished as a Masters dissertation, and of such a small scale. It is not clear how it can inform the wider understanding of LMHC.

The other UK unpublished report (Rotherham Priority Health NHS Trust, 2001) provided an evaluation of a DSH service. The service also appeared to make some initial assessments of those with mental health issues but this aspect of the service was not clearly described in the report. The service was a 24 hour 365 days per year service at the time of the data collection (2000). The client postal survey received a 23% response rate. The majority of questions simply asked about how the service users had used the service rather than gaining any information about satisfaction with or opinions about the service. A question about how the service could be improved was included and offered the service users a space for free text, there was also an opportunity to give comments at the end of the survey. Responses to open ended questions were given but these were reported directly and not summarised. These data suggested that on the whole the service was well

received by service users. Section 3.4.1 considers the issues with measuring LMH service user satisfaction.

This initial review of the literature on service users' experience of LMHC indicates that no studies had been published that explored, in depth, the experiences of LMH service users; either within the UK or the wider international literature. All published and unpublished literature appears to relate to satisfaction or outcomes but not to the overall experience of service users. A search of the grey literature was also unable to identify any studies which covered these experiences. However, following the initial literature review a further Australian study (Summers & Happell, 2003) was identified in the published literature. This study is described below in section 2.5.3.

### ***2.5.3 The development of research into service users' experiences of liaison mental health care during the evolution of the current study***

Two publications from the interview study reported here were also published, summarising the initial analysis of the service user interviews and also a postal survey. Firstly Callaghan et al (2002) reported on a postal survey of service users of LMHC (n=71). The survey was pre-validated Verna Service Satisfaction Survey (Ruggeri & Dall'Agnola, 1993; Leese et al, 1998). The response rate was poor (27%), a common problem with postal satisfaction surveys to mental health service users (Green et al, 2001). High levels of satisfaction were reported with the service. The opportunity to provide written

feedback was included and three themes emerged. Firstly, service users identified positive staff attitudes. Secondly, service users felt positive about the listening skills of staff; however six people reported 'not being understood'. Waiting time produced the most dissatisfaction: 18 people reported that the waiting time was unsatisfactory, whilst only four people were satisfied by the waiting time. The study also reported a summary of the interview findings, which were elaborated and combined with other stakeholder data and reported by Eales et al (2006). Three themes emerged from the content analysis (Berg, 1998) of service user and other stakeholders' evaluation. The three key themes were the practicalities of the service including waiting time, the staffing profile and receiving the service, which included issues such as the opportunity to talk and outcomes.

The Summers and Happell (2003) study, a telephone survey of 136 patients who used a psychiatric service in the ED found service users to be overwhelmingly positive towards the service they received. Questions elicited responses about receiving information, professional manner of staff, and listening to problems. Patients were able to expand on their responses and offered further information and examples of these are given in the paper, reviewed in depth within the literature review (section 3.7.6). The comments made by patients during the telephone survey led Summers and Happell (2003) to recommend that those with mental health issues required prioritisation in line with that provided for those needing other specialist interventions in the ED for physical health conditions.

Within the three papers reporting on two surveys and the primary data analysis of stakeholders, including service users, one theme was common; that of waiting time, clearly an aspect of the LMHS experience which is problematic for service users in both the UK and Australia. The three studies identified and reviewed do not offer an in depth analysis of service user experiences of LMHC, they explored in the main satisfaction with the service. Two utilised predetermined questions to obtain information about satisfaction. Therefore the analysis of the interview data reported in this thesis presents an original and important addition to current knowledge in the field.

#### **2.5.4 The need for in-depth consideration of service users' experiences of liaison mental health care**

Exploring the literature on service user satisfaction with and experiences of LMHC, there was no evidence that attempts had been made to understand in any detail the experiences of LMH service users. The paucity of published research which explored service users' experiences of LMHS, reported up to 2003 (as described in section 2.5.2 above) remained the case when the literature was reviewed again, up to 2013 (see section 3.7.6). Despite an increasing interest within the policy arena, integrating the experiences of service users into the outcome measures for services and the increasing focus on the patient experience (DH, 2007; DH, 2011a; National Institute for Health & Clinical Excellence (NICE), 2011; NICE, 2012).

Both NICE and the Department of Health have recently published frameworks and guidelines that emphasise the importance of understanding patient experiences within the NHS (DH, 2011a), within adult NHS services (NICE, 2012) and adult mental health (NICE, 2011). These guidelines follow the Department of Health requirement for NHS Trusts to consider public and patient involvement a “must do” activity (DH, 2007). This DH (2007) briefing stresses the importance for the NHS of not only involving the public and patients (as consumers of health care services) in processes which change the delivery of services, such as commissioning and re-provision but also identifies the need to “*make sure that the care they [NHS services] provide fully reflect what people need and how they prefer it to be provided*” (DH, 2007 pp3). Therefore it is imperative that LMHS understand the experiences and therefore what matters to LMH service users.

#### ***2.5.5 Primary data analysis of service users’ experiences of liaison mental health care during the evaluation of the liaison mental health service at a London Hospital study***

During the funded research, which the author began in 2000, the service user interviews were analysed using content analysis (Berg, 1998) and the resulting themes were integrated with those of professional stakeholders to give an overall account of satisfaction with a liaison mental health service (Eales et al, 2006). In terms of the data collected, no further or more detailed analysis was possible due to the time and funding constraints of the original study, and all reports and publications arising from this work incorporated data on the combined stakeholder views.

As the researcher conducting the study, I felt that the data elicited from the service users for the evaluation study was not only immensely interesting and very rich in information about the service users' experience, but that reports to date had only captured their satisfaction with the service. In considering the questions about their 'satisfaction', service users interviewed discussed their individual stories of their experiences of the service, they did not report or discuss only satisfaction. I felt that the data analysis so far had not explored adequately this richness of information about their experiences and within the limitations of the funded study I knew this would not occur. This gave rise to the idea of a more substantive analysis, as reported in this thesis, as a secondary data analysis (see section 2.6).

#### **2.5.6 Service users' experiences of liaison mental health care matter**

The identification of a lack of published information about service users' experiences and the richness of the data available led the author to identify the potential to undertake a secondary analysis of the existing data set, to explore the depth of information provided with a view to ensure that, the voices of LHM service users could be heard.

*"Patients' experiences are not an alternative to the evidence base – they are part of it; to dismiss them as 'anecdotes' is a serious misunderstanding."*

(Zeibland & Herxheimer, 2008 pp439)

Understanding and acknowledging the value of the service user voice has been a long standing commitment for the researcher and has affected her career development, shaping her approach to mental health nursing. The service user movement has increased engagement over time with the academic and research community and the debates about the attainment of 'gold standard' research with an independent and objective stance verses the inclusion of service user voice in developing services and delivering care continues (Beresford, 2003).

## **2.6 Secondary data analysis: a responsibility to explore and understand under-utilised data**

The opportunity to utilise data already available to answer new research questions or to follow up initial findings and develop them further is a methodology known as secondary data analysis (Szabo & Strang, 1997). The use of pre-existing data had a clear tradition in quantitative research, this was not the case in qualitative research where until the 1990s there had been little acceptance of the re-use of research data (Heaton, 2004). Secondary data analysis had a tradition in naturally occurring data but not in the re-use of pre-existing data (Bishop, 2007).

Within health and social sciences the use of data for secondary analysis is a more recent development which can attract some controversy because the participants are unable to give their informed consent for the use of data other than that originally intended (Heaton 2004). Heaton (2004) as a



primary cited author in this field, argued that to re-use one's own data, was an acceptable methodological approach (section 4.1 in methodology chapter explores secondary data analysis in further depth). In summarising the literature on secondary analysis, Heaton (2004) concluded that secondary analysis of data to answer new research questions has gained acceptability in qualitative research. This is further evidenced by the Economic and Social Research Council (ESRC, 2012) call for proposals for secondary analysis of existing data sets (discussed below).

### ***2.6.1 Secondary data analysis a developing methodology***

Recognition has grown for the need to utilise existing data sets, and to synthesise existing qualitative research evidence, for example, as seen with the 2012 ESRC funded research call., Some funding agencies, for example the ESRC, now require the research team to ask participants at the point of gaining consent if they will grant consent to archive the data collected for future analysis. Where data is used to develop the original research aims and not to consider a different topic area, the ethical issues are seen to be less concerning, because the data continues to be used for the purpose for which it was collected (Heaton, 2004). Greater consideration of ethical issues is required where the data is to be used for a purpose unrelated to the original research project.

In the case of secondary data analysis for the proposed study, the information poster used in the original study explained that the data was to

be collected to explore experiences of LMHC. The argument can be made that, particularly where human participants are involved, we have an ethical duty to ensure that the data we obtain as researchers is fully explored, rather than undertaking new research with service users when the data may already be available to answer our proposed research question (Szabo & Strang, 1997). This is consistent with respecting the time and generosity of service users as they share their experiences with a view to informing service improvements (DH, 2007).

Interest in, and funding for, secondary analysis of data is growing. The ESRC launched its first ever call for proposals for the newly established Secondary Data Analysis Initiative in 2012 (ESRC, 2012). This initiative recognises the importance of fully utilising existing research data sets. The initiative aims to fund projects offering “high impact in policy and practitioner relevant research through deeper exploration of the major data sources” (ESRC, 2012 pp1). This initiative is an important acknowledgement of the role that secondary analysis could have in enhancing the gains from research data without the need to conduct further research. The call for proposals from the ESRC shows the latest attitudes to secondary data analysis. Hence, the author would argue that it was appropriate and ethically acceptable to conduct a secondary analysis of the interview data from the original study, and that such analysis was likely to lead to new knowledge about the service user experience.

## **2.7 Choosing a methodology for the secondary data analysis**

The methodology chosen for the analysis of the data was that of constant comparative analysis. This is the method of data analysis utilised in grounded theory methodology (Dey, 2008). Grounded theory is a methodology for qualitative data analysis which seeks to generate theory from the analysis of the data. This is an inductive approach, rather than a deductive approach. Grounded theory requires the researcher to be open to the data and let the data speak for itself, rather than to come to the data with any preconceived understanding of the topic or a hypothesis on which to basis the analysis (Glaser & Strauss, 1967).

Grounded theory methodology is particularly appropriate when there is little known about an area of enquiry or social process. The originators of the grounded theory methodology were Glaser and Strauss (1967). Following a divergence in their thinking two strands of grounded theory later developed that of Glaser (1992) and Strauss and Corbin (1990) followed latterly by Corbin and Strauss (2008); although Dey (1999) contested that there were as many methods of grounded theory as there were grounded theorists. The statement by Dey (1999) may well be an exaggeration however, much methodological debate has been undertaken over the life of grounded theory regarding what is and what is not an appropriate application of the grounded theory methodology.

The use of the constant comparative method, only one aspect of the overall grounded theory method, for this secondary data analysis, has been previously undertaken within nursing research and utilising secondary data analysis (Szabo & Strang, 1997). Corbin and Strauss (2008) also directly identify the analysis of previously collected data as a legitimate use of the constant comparative method. The in depth nature of the analysis, the level of structured guidance available on the process of constant comparative analysis, as described by Strauss and Corbin (1990) and the potential to generate theoretical understandings of the data analysis could potentially lend new insights in to a previously poorly researched area of service user experience of LMHC. This was the rationale for the use of the constant comparative analysis.

## **2.8 Summary statement: why data on service users' experiences of liaison mental health care matter**

Secondary analysis of qualitative data (Heaton, 2004), and in particular the grounded theory approach of constant comparative analysis (Strauss & Corbin, 1990; Dey, 1999), offers opportunity to explore already collected data in new and more in depth ways. Undertaking secondary data analysis of the service user interviews is a pragmatic approach to ensuring that the as yet unheard voices of LMH service users are considered and understood. It has been suggested above, and the following literature review (Chapter 3) will demonstrate further, that at the development of this study there was a gap in the reported literature in LMHC. Literature which gives an in depth account of service users' experiences of LMHC does not exist. Therefore an opportunity

presents to contribute a currently unique and original insight into the experiences of LMHC service users.

Over the span of time taken to undertake this study, there remains a lack of published data and interpretation of LMH service users' experiences. As a consequence utilising available empirical material from service user experiences of LMHS to explore in detail service users' experiences is a valid and important approach to inform contemporary integrated and cost efficient service provision. Current health care policy agenda to reduce the gap between the care of mental and physical health (HM Government, 2011) and recent evaluations of LMHC suggest that every hospital should have a LMHS (Parsonage et al, 2012). It can be argued that, over time, LMHS has become ever more important if healthcare professionals are to provide positive mental health care in non-mental health settings which adequately takes into account the service users personal experiences.

## **2.9 Research aims and objectives**

The background and study rationale outlined above has identified a gap in the research evidence related to LMHC service users. This is elaborated and further verified following the literature review process as presented next in chapter 3. Therefore, the following research aims, objectives and questions have been identified and used to focus the study's progression.

### **2.9.1 Study Aim:**

To explore and theoretically analyse experiences of people who have used liaison mental health services.

### **2.9.2 Objectives:**

1. To critically consider the impact and implications of research (1975 – 2013) and policy development (1990 – 2013) in the area of Liaison Mental Health Care.
2. To use constant comparative analysis, an aspect of grounded theory, to analyse and present experiences of liaison mental health care service users.
3. To identify and discuss theoretical understanding of the experiences of mental health liaison service users from a case study site in inner London.
4. To provide policy and practice improvement recommendations for contemporary liaison mental health based on the application of findings from the study.

### **2.9.3 Critical research questions guiding the study are:**

1. What are the origins of Liaison mental health care?
2. How has LMHC evolved and what is the current evidence base?
3. What are service users' experiences of liaison mental health care?
4. What can we learn from service users' experiences of liaison mental health care and how should this impact upon policy, practice, research and education?

The next chapter addresses the origins and evolution of LMHC, as part of the critical evaluation question identified above (section 2.9.3). This takes the form of a systematic review of the available literature on the structure, process and outcome of liaison mental health care from 1975 to 2000; followed by an update of this literature review covering the intervening period 2000 to 2003 and the period of the study (2003 – 2013). The literature review is followed by an exploration of the policy directions and drivers at the beginning of the study and the changes which have occurred over the course of the study.





### **3 LITERATURE REVIEW**

Over the course of the study, the level of research into LMHC has developed, although many gaps remain in the available evidence base. Therefore, this literature review has been organised to cover several key areas that include:

- A history of the development of LMHC and LMHS as reported in the professional literature is provided, followed by a summary of the UK policy context at the time the research study began (2003).
- A review of the structure, process and outcome of LMHC (1975-2000), completed at the inception of the study, is presented.
- Later sections present updates on the policy context and also an update on the review of structure, process and outcome of LMHC over a decade of political and practice changes (2000 – 2013).
- Finally, this review considers available literature relating to the service users' experience of mental health care (up to 2013).

#### **3.1 History of Liaison Mental health Services**

The published literature suggests the origins of Liaison Mental Health lie in the United States of America (USA). Origins have been traced to 1751 in the USA and in particular the work of the Pennsylvania Hospital in Philadelphia (Schwab, 1989). J. Montgomery Mosher is regarded as the first general hospital psychiatrist (Schwab, 1989) and in 1909 was the first to outline basic principles of liaison mental health care. The sixth of Mosher's principles addresses the importance of mental health services liaising with other general hospital specialist services (Mosher, 1909).

### 3.1.1 Phases of Liaison Development

Since the last part of the 19<sup>th</sup> Century it is claimed that LMHS evolved in four discrete phases (Schwab, 1989; see Table 3. 1 below).

Phase	Date	Description
Preliminary	1885-1929	First awareness of the need for liaison psychiatry and the first clinicians working
Pioneering	1930-1945	Education programs develop, interest in the emerging psychosomatic movement.
Developmental	1946-1979	Expansion of services, multi-professional teams become established.
Consolidation	1980-1989	Collapsing/ reduction of services, driven by monetary concerns, yet an increasing recognition of the incidence of mental illness in the general population.

**Table 3.1: Schwab's (1989) Phases of Liaison Development**

In the final consolidation phase of Schwab's (1989) development of LMHS in the USA, the end of the 1980s saw a reduction of services despite increasing recognition of rates of mental illness in the general population.

#### **3.1.1.1 Liaison Mental Health Nursing**

Liaison Mental Health Nursing developed in the USA during the 1960s (Robinson, 1982; Roberts, 1997). According to Robinson (1987), liaison nurses focused on the interpersonal problems between nurses and service users in contrast to 'liaison doctoring', where the focus was on diagnosis and treatment of an illness. Reference to liaison mental health nursing appeared for the first time in the UK in 1989 when the work of Jones (1989) and Tunmore (1989) described liaison mental health nurses working in medicine and oncology, respectively.

#### **3.1.2 Origins of Liaison Mental Health Care in the UK**

Mayou (1990) traced the origins of liaison psychiatry in the UK to the early 20<sup>th</sup> Century but argued that it was not until the beginning of World War II that specialists in psychological medicine made a significant contribution to the treatment of general medical patients. LMHS developed in the UK health care services as a direct response to increasing evidence that physical illnesses often have psychosocial consequences. For example, 65% of medical in-patients were estimated as having psychiatric symptoms (Gomez, 1987).

Callaghan et al (2003) have defined LMHC as

*“Services provided by mental health specialists in general health settings whether provided by mental health nurses or psychiatrists alone, or as part of a multidisciplinary team ... characterised by*

*liaison, consultation, education, and in some cases direct intervention with service users.”*

(Callaghan et al, 2003 pp157)

#### *3.1.2.1 Historical Overview*

From this brief overview, it can be seen that LMHC has developed and adapted over the 20<sup>th</sup> Century, with UK services repeating developments taking place in the USA. Across the 20<sup>th</sup> Century interest in LMHC increased at a time when psychological distress was being identified in war veterans. More specifically, LMHN does not appear in the published literature until the 1960s. Whilst in the USA published literature suggests a reduction in services towards the end of the 20<sup>th</sup> century, conversely in the UK there appeared to be an increasing level of publications relating to LMHN in the UK; suggesting an increase in service provision. The next section which describes the UK policy context sheds further light on the policy developments that may have led to the increased interest and reporting of LMH UK service provision.

### **3.2 The United Kingdom Policy Context (1990 -2000)**

This section explores the expanding number of policies around LMHS provision at the time leading up to this study's commencement.

### **3.2.1 Government guidelines for self-harm reduction**

The 1990s saw an increasing interest in the reduction of deliberate self-harm (DSH) and suicide, plus the identification of the need to develop more responsive, service user focused, mental healthcare provision. In the UK, LMHS mainly involved the assessment and treatment of suicide attempts and DSH, when service users attend acute and emergency care services. All government guidelines on self-harm since 1990 have advocated access to a psychosocial assessment following any DSH; this service is usually offered by a LMHS (DH, 1992; DH, 1998; DH, 1999a; DH, 1999b). These guidelines have been reinforced by the National Institute of Clinical Excellence clinical guidelines on the management of self-harm (NICE, 2004).

A review of mental health nursing in 1994 (DH, 1994) identified the existence of mental health nurses in EDs and other general health care settings. As a consequence, the Department of Health recommended research should be conducted to examine the potential value of liaison mental health nursing. Addressing Acute Concerns (DH, 1999a) refers to the 1994 recommendations regarding liaison nursing and suggests that LMHS may reduce admissions to in-patient units by finding alternative community-based services. However it appears that little research has been conducted to examine the impact of such services (Callaghan et al, 2003). The National Service Framework for Mental Health (DH, 1999c) generated an increase in the number of LMHS. In many cases acute mental health NHS Trusts addressed the requirement for 24 hour access to services for all people with

a mental health need by introducing or increasing the capacity of Emergency Department LMHS (RCPsych, 2004).

### ***3.2.2 Modernising mental health care***

Modernising Mental Health Services Safe, Sound & Supportive (DH, 1998) identified the need to provide 24 hour access to mental health services such as that provided by many EDs to those with physical health needs. Twenty-four hour access to a skilled mental health assessor was highlighted as central to the concept of safe, sound and supportive services, especially for those presenting to mental health services for the first time. This assessment needed to include 'good risk management'. In Saving Lives Our Healthier Nation (DH, 1999b) suicide is identified as a key area for improvement. The target in this document was to cut suicide by one fifth by 2010. This document placed assessment of suicide risk and appropriate follow-up at the centre of plans to reduce suicide. As many suicide and self-harm attempts are seen in the ED, LMHS services carry out many of the assessments in support of the suicide reduction targets.

The National Service Framework for Mental Health (DH, 1999c) set seven standards for improving mental health care. Several standards identified the need for quick, 24-hour access to services and this appears to have led to a resurgence of interest in LMHS. In many areas local mental health trusts planned to meet commitments to 24 hour access with improved provision of

ED based LMHS and the provision of emergency clinics specifically for those with mental health needs.

The Royal College of Psychiatrists released several reports relating to the provision of LMHS (RCPsych, 1994; Royal College of Physicians & RCPsych, 1995; RCPsych, 1996; Royal College of Surgeons of England & RCPsych; 1997). In 1994, the RCPsych outlined how those who present to hospital with suicide attempts and DSH should be treated both by the hospital's medical teams and specialist mental health staff. The report sets out guidelines for assessment by medical staff and minimum training standards for specialist assessors. The 1994 Report recommends every hospital to set up a DSH planning group. As with the RCPsych report on psychiatric services to A&E departments (RCPsych, 1996) this report is not specific about which discipline within a liaison service should complete assessment. The report supports the comprehensive assessment of every self-harm patient who is seen in the ED or admitted to a hospital ward.

Three of the RCPsych reports (Royal College of Physicians & RCPsych, 1995; RCPsych, 1996 & Royal College of Surgeons of England & RCPsych, 1997) identify the need for multi-disciplinary liaison services to offer support with psychiatric and psychological needs to patients in the ED and in wards of hospitals.

At the end of the 20<sup>th</sup> century the UK saw increasing development of LMHS within the general hospital setting, particularly within the ED. This was a result of restated government targets to reduce suicide by 10% between 1999 and 2010. This goal led to the restatement of the need for psychosocial assessment of self-harm and suicides attempts when people presented to hospital via the ED. LMHS were at the forefront of meeting these targets and 24 hour LMHS began to develop offering assessment following DSH but also to a lesser or greater extent services to people with mental health issues across the wider general hospital services. The next section explores the types of services that had been reported and evaluated within the published literature by the end of the 20<sup>th</sup> century.

### **3.3 A Review of the Structure, Process and Outcome of Liaison Mental health Services (up to 2000).**

A review of empirical research studying the structure, process and outcome of general LMHS was undertaken in 2001 and published as Callaghan et al (2003) (Appendix 1). The author was instrumental in conducting the literature review, developing the search strategy, undertaking the searches and undertaking the initial sorting and reviewing of papers. That literature review is in part reproduced here in setting out the systematic literature review undertaken to identify the nature of LMHC. The inclusion and exclusion criteria and search strategy utilised for the review are outlined and the findings of the review are given. This review seeks to contextualise the current study in relation to how LMHS were operating at the inception of this study, the process of LMHC and also how LMHS were being evaluated.



The search strategy for the review was developed using the Centre for Reviews and Dissemination guidelines (CRD, 2001). All available literature that met the criteria outlined below was included. Twelve electronic databases were searched (presented in table 3.2 below).

DATABASE	DATES	DATABASE	DATES
Medline	1975-2000	British Nursing Index	1985-1986
Assia	1992-1998	CINHAL	1982-2001
Embase: Psychiatry	1987-2000	RCN Library	N/A
National Research Register	N/A (followed by author search on Medline)	Nursing Collection	1995-2001
Psychinfo	1984-2001	Cochrane	1st Quarter 2001
Database of abstracts of reviews	1 <sup>st</sup> Quarter 2001	Best Evidence	1991-2001

**Table 3.2: Databases searched and dates.**

Following an initial exploratory search of “*liaison and psychiatry*” through Medline which yielded 284 articles, it was clear that this filter would produce many clinical related articles that would not fit the inclusion criteria of a review of the structure process and outcome rather than individual clinical interventions. The following search filter was identified:

((*mental and health*) or *psychiatry*) and *liaison* and *evaluation*).

Limits: 1975 – present, English Language

Where this filter yielded few or no hits one or more of the filter terms was removed.

All literature was obtained unless the abstract clearly met the exclusion criteria. Websites of mental health related organisations (c.f. Royal College of Psychiatrists, Mind, Rethink, Sainsbury Centre for Mental Health, Department of Health) were screened for relevant information. The reference lists of all included documents were scanned for relevant articles. As key publications in the relevant disciplines to LMHC hand searches were completed of the *British Journal of Psychiatry*, the *Journal of Advanced Nursing* and the *British Journal of Social Work* from 1995 to 2001.

### **3.3.1 Inclusion and exclusion criteria**

From an initial review of the literature, the reviewers (Sarah Eales (SE) and Patrick Callaghan (PC) agreed the following inclusion and exclusion criteria.

#### 3.3.1.1 *Inclusion criteria*

1. Empirical literature giving information regarding the provision of liaison mental health services.
2. Liaison mental health services operating within Accident & Emergency.
3. Liaison mental health services operating within at least two different specialities.
4. Both qualitative and quantitative studies and descriptions of service provision.
5. Services that comprised a single discipline or multidisciplinary.
6. Review Papers synthesising empirical research.

#### 3.3.1.2 *Exclusion criteria*

1. Original empirical research prior to 1975, as substantive reviews exist covering this material.
2. Literature regarding treatment options for clinical work within liaison mental health services.
3. Literature not available in the English language.
4. Single speciality services, for example, a liaison service provided solely to an oncology unit.
5. Services covering only deliberate self-harm presentations.

The review sought to achieve an articulation of the effective provision of a LMHS. Single specialist services, including those for self-harm were not considered to meet the criteria of a LMHS in so much as they focused on a single speciality or a single service user presentation and did not offer

services across a range of general hospital departments or mental health needs and therefore lay outside of the scope of the review.

The current author (SE) and one other member of the original funded research project team (PC) extracted data using a specially designed form based upon those reported by the Centre for Reviews and Dissemination. All articles were read independently by one of the reviewers, once all articles had been read the inclusion and exclusion criteria were reviewed. Where articles fell outside the inclusion criteria the paper was read by both reviewers and the decision taken together to include or exclude. Using these criteria the reviewers applied the criteria to 110 papers, 48 of which met the inclusion criteria.

The systematic literature review (1975-2000) identified one review paper, 30 descriptive and 17 evaluation studies. The evaluation studies demonstrated that LMHS reduce not only the levels of psychological morbidity, but also cardiac mortality, health care costs, as well as an improvement in physicians' skills in treating psychological problems and increased referrals for follow-up appointments. Most of the literature published during the search period (up until 2000) draws on research conducted in Europe. An overview of the studies included in the review is offered in Appendix 1.

### **3.3.2 *Liaison Mental Health Service Structure***

Callaghan et al (2003) identified there to be various configurations of LMHS. These included: i) a single discipline (mental health trained) nurse; ii) psychiatrist services; iii) multi-disciplinary services; including nurses, doctors, social workers and/or psychologists. In 9 (32%) of the reported studies the service was reported as multidisciplinary; comprising nurses, social workers, psychologists and psychiatrists. Another 9 (32%) studies were reports of teams comprising only psychiatrists, whereas 5 (18%) liaison teams consisted only of nurses. Three (11%) teams comprised nurses and psychiatrists. Of the remaining 2 (7%) studies, the mental health needs of clients were dealt with by the general A & E staff, whereas in the other study it was not clear how the service was configured. Seventeen (63%) LMHS were located in general hospitals outside of the A & E department, 10 (37%) were located in A & E departments. Slightly more (4, 27%) LMHS in the UK were located in A & E departments than in other parts of the hospital (3, 20%). However, in the US and other parts of Europe, LMHS were located outside the A & E department. In one US study referrals were made to either a Consultation-Liaison Nurse or a Psychiatrist (Stickney & Hall, 1981). The majority of services were located in the general hospital but outside the Emergency Department. The reasons why service users were referred to psychiatrists and nurses were similar across the studies reviewed. However, psychiatrists saw every service user referred to them, whilst nurses saw only 58% of those referred and advised colleagues on the management of the remaining service users. The most common presenting problem amongst service users was found to be depression.

### **3.3.3 *Process of Liaison Mental Health Services***

The 26 studies that described referrals to LMHS reported on 19,388 assessments conducted over periods ranging from 3 months (e.g. Ryrle et al, 1997) to 5 years (Aghanwa et al, 1996), with a median audit period of 1 year. Fifteen (58%) studies reported on the gender of those referred and the ratio of males to females was on average 1.08-1. The age of referrals was reported in 14 studies, 10 of which stated the mean age, while 4 reported age ranges. The median age of referrals calculated from all 10 studies reporting specific ages was 41 years (range - 17 to over 65). In one study (Mayou et al, 1994) a quarter of the sample were reportedly aged over 65 years. Aside from gender and age, no other demographic characteristics (e.g. marital status, ethnicity, level of education, employment and accommodation status) were reported.

There was little consensus in referral patterns to liaison services. In one study (Reet & Brendon, 2001) weekends attracted slightly more referrals than weekdays, whereas in another (Beech et al, 2000) weekdays attracted more referrals. May and July were the months attracting more referrals than at any other time of the year (Reet & Brendon, 2001).

The main presenting problems and diagnoses of referrals were reported in 21 studies and these were depression (n=11), DSH (n=2), acute situational distress (n=2), with substance misuse, functional psychosis, personality disorder, aggression/ disturbed behaviour, acute brain syndrome and organic

disorder reported in only one study each. It was unsurprising that depression was the main diagnosis of people referred to LMHS because this represented the most frequent mental health issue identified within the general population (Andrews et al, 2005) and furthermore showed an increased incidence in those with physical health issues over the general population (Creed & Guthrie, 1996). The majority of these studies were based on UK services.

The ten years, 1990 to 2000 saw a shift in the priority of mental health services towards those with so-called severe and enduring mental illnesses and who almost certainly have a diagnosis of Schizophrenia, increasingly with a concomitant substance misuse problem (DH, 1999c). The consequence of this shift was that Community Mental Health Teams work largely with this client group (DH, 1999c). Also, this is the group most likely to be admitted to in-patient psychiatric wards (Gournay et al, 1997). People with depression may miss out on receiving appropriate treatment and are likely to appear at GP surgeries and/or be referred to, or refer themselves to, LMHS, especially those based in A & E departments.

Some studies report that clients were referred to LMHS because they had harmed themselves (Beech et al, 2000, Ellis & Lewis, 1997, Ryrle et al, 1997). While not everyone who self-harms is depressed, there is a strong link between these two presentations (World Health Organization, 2000). With a wide variety of data reported, which made comparisons difficult, there is little similarity as to who is referred to LMHS, except to note that 52% of

services were responding to service users with depression as the most frequent presenting problem and/ or diagnosis for service users.

### **3.3.4 Outcomes of Liaison Mental Health Services**

From the review it was clear that the outcomes for service users included referral onward to specialist services, brief counselling, outpatient follow-up and admission to in-patient care. This was considered to be an important function of a liaison mental health professional who, in this context, acted as a channel through which service users with mental health issues may access mental health services that are appropriate to their needs (Ryan et al, 1997). Some studies have found that liaison professionals may provide mental health care directly, but they were more likely to offer advice to non-mental health professionals, and refer service users to other specialist services (Tunmore, 1994; Reet & Brendon, 2001).

Overall, the review found that professionals reported satisfaction with LMHS. In particular, satisfaction was expressed by professionals in relation to the speed of response, quality of assessments, documentation and outcome (Brendon & Reet, 2000). In one study carried out in Canada (Newton & Wilson, 1990) general nurses were most satisfied by the liaison nurses' work with families, the ease of referral, and the promptness of the service. However the same study reported that general nurses were least satisfied with liaison nurses' documentation of their work and their outcome recommendations. In another study liaison nurses were valued by professionals because they were available, objective, had good counselling



skills and supported other staff (Roberts, 1998). Gillette et al (1996) reported that liaison nurses in Australia improved coordination and continuity of care and communication.

Interestingly, fewer than half the studies reviewed concerning the evaluation of LMHS asked service users what they thought of the service. This was perhaps surprising given that a great deal of liaison work involves direct contact with service users. In the studies where service users were asked to comment on the service they reported satisfaction with the care provided by liaison nurses (Priami & Plati, 1997), valued the information about their treatment they received from liaison nurses (Nichols, 1994) and expressed extreme satisfaction overall (Rotherham Priority Health NHS Trust, 2001). In all of these studies the service users' views were elicited by the use of a structured questionnaire; in two cases this was self-administered (Nichols, 1994; Rotherham Priority Health NHS Trust, 2001) and in the third case it was administered by the clinician who had provided the liaison service (Priami & Plati, 1997).

The primary outcomes for those referred to LMHS were reported in 11 studies and include onward referral to specialist services (n=4), brief counselling/psychotherapy (n=2), out-patient follow-up (n=2), prescribed medication (n=1), admitted to inpatient care (n=1) and advice on health and social care issues (n=1)

The outcomes illustrate the range of interventions provided by LMHS. An important function of a LMH professional is to act as a channel through which people with mental health issues may access mental health services appropriate to their needs. As the audits in this review showed, LMH professionals may provide the care directly in the form of brief interventions, but they were more likely to offer advice to non-mental health colleagues, and refer clients to other specialist services.

### ***3.3.5 Other countries reporting on Liaison Mental Health Service provision***

Aside from the audits reporting the general characteristics to LMHS, other studies examined different facets of service provision. One study (Collins et al, 1992) examined the use of LMHS among different cultural groups in San Diego, California based on a retrospective review of 476 patients. In this study the rate of referral was lower for those the researchers characterised as 'Hispanics' than those characterised as 'Anglos', 'Blacks' and 'Asians'. Also, there were more requests for assessment of depression and suicide among so-called Hispanics; there were more requests for assessment of 'grossly abnormal mental status' among so-called 'Blacks'. Finally, those labeled 'Hispanics' were more often diagnosed as adjustment disorder, those labelled 'Blacks' were more often diagnosed with primary thought disorder and those labelled 'Anglos' were more often diagnosed with dementia.

The organization of 56 LMH services in 13 European countries was the subject of the European Consultation Liaison Workgroup Collaborative Study (Huyse et al, 2000). The results of this study showed wide variation in size and membership of LMH teams. In general two models emerged [1] the uni-disciplinary model with input from psychiatrists only, [2] the multidisciplinary model with input from psychiatrists, social workers, nurses and psychologists. The larger university hospitals had more uni-disciplinary services. The services with the lowest multidisciplinary input were those in Italy, Portugal and Greece.

In a variation from the general auditing of LMH services, one study (Popkin et al, 1983) investigated the concordance rates between physicians and liaison psychiatrists at the University of Minnesota Hospital, Minneapolis, USA. Concordance rates were highest for drug recommendations and lowest for surgery recommendations. The age of the patient, the waiting time for the consult and a diagnosis of organic disorder were linked significantly to concordance.

### ***3.3.6 Evidence relating to Liaison Mental Health Nursing***

The activities of LMHN were reported in two studies. In the first study (Reet & Brendon, 2001) it was reported that clinical work accounted for the majority (36%) of activity of LMHN, followed by administration (20%), supervision (17%), audit and research (11%), teaching (10%) and meetings (6%). Most (73%) of the clinical work involved initial and follow-up face-to-face contact with clients; 19% of clinical work was by telephone. The second study (Tunmore, 1994) described the role of 32 LMHN, 29 (90%) of whom were at

the upper end of the clinical grading structure. Most (40%) were working with clients with DSH and 70% of referrals to the LMHN were to see clients directly. One study showed that most (13) referrals involve 60 minutes of contact with clients (Beech et al., 2000).

### ***3.3.7 Key findings from the literature review (2000)***

The literature review of the descriptive studies showed considerable variation in the type of data reported and the period covered by the studies. When the audit period was less than one year the data may have been unrepresentative, failing to capture any seasonal variations in referral rates. The failure of most studies to report demographic data beyond gender and age made it difficult to show how LMHS were meeting the needs of diverse groups that inhabit the urban areas served by most services reporting data. The use of retrospective audits was common among studies reported and this represented a significant weakness of the literature in that researchers were restricted to reporting data collected initially by others. The European-based literature focused on reporting epidemiological data, whereas the US-based literature described the liaison process more often. The structure and processes of liaison services were frequently reported. However, outcomes were seldom reported. The main weakness of audits was that they simply described the liaison services but reported nothing of their value.

Much of the international literature was descriptive and reported only on the structure and process of liaison work (Callaghan et al, 2003). There was a wide variation in the methodological quality of published studies. None of the

reviewed studies adhered to the quality criteria outlined by the Centre for Reviews and Dissemination (CRD, 2001). For example, the use of convenience samples increased the likelihood that the samples were unrepresentative of the sampling frame. Also, none of the studies provided a justification for the selected sample sizes resulting in the possibility of lack of validity of reported results and conclusions. For example, one study (Fitt, 1983) reports that a liaison service had little influence in interdisciplinary cooperation since no statistically significant differences on this outcome were reported. However, these results are questionable on the basis that a sample size of 80 was probably insufficient to detect these differences using this type of design (Cohen, 1992). A similar problem occurs in another study (Bruce et al, 1999) that shows that specialist psychiatric services attached to a General Practice had little effect on Health of the Nation Outcome Scale (HoNOS) scores.

Ten of the reviewed studies used questionnaires to measure various constructs. However, few of these studies reported on the psychometric status of the measure and this begs the question as to the reliability and validity of such measures. The use of measures that have poor psychometric qualities threatens the internal and external validity of the studies.

The response rates in studies using surveys ranged from 23% (Rotherham Priority Health NHS Trust, 2001) to 92% (Newton & Wilson, 1990) with a median of 39%. The relatively low median response rate compounded the sampling problems associated with the use of convenience samples. In the

studies where the response rate was low (e.g. Rotherham Priority Health NHS Trust, 2001), the researchers did not report if the responders differed from the non-responders in terms of demographic profile. Less than half the studies evaluating LMHS asked service users what they thought of the service. This was surprising given that a great deal of liaison work involves direct contact with service users.

On the whole, respondents reported satisfaction with LMHS when researchers canvassed their views. In particular, satisfaction was expressed in relation to the speed of response, quality of assessments, documentation and outcome (Brendon & Reet, 2000). In one Canadian study (Newton & Wilson, 1990) general nurses were most satisfied by liaison nurses' work with families, the ease of referral to, and the promptness of the service. In the same study, nurses were least satisfied with liaison nurses' documentation of their work and their outcome recommendations. In one study (Roberts, 1998) liaison nurses were valued because they were available, objective, had good counselling skills and supported other staff.

In a US-based study (Karasu et al., 1977), physicians valued the advice on patient management and follow-up visits most, and teaching and resolving conflicts the least when evaluating a multidisciplinary liaison team. Senior staff were more likely than junior staff to value the liaison service. An Australian study (Gillette et al., 1996) reported that liaison nurses improved coordination and continuity of care and communication.

Clients reported satisfaction with the care provided by LMHN (Priami & Plati, 1997), valued the information about their treatment they received from LMHN (Nichols, 1994) and expressed extreme satisfaction overall (Rotherham Priority Health NHS Trust, 2001). Clients' length of stay at a psychiatric facility in Australia decreased following the introduction of a LMHN service (Gillette et al, 1996).

The number of psychosocial referrals doubled, and the number of people with mental health problems re-presenting at A & E reduced, following the introduction of a multidisciplinary liaison service in the UK (Morgan & Coleman, 2000). The attachment of Community Psychiatric Nurses to an A & E department was associated with an increase clients' use of mental health services and reduced the demands on other services (Storer et al, 1987).

Studies using controlled trials and quasi-experimental designs reported that liaison services made little difference to the number of sitters needed to attend clients with mental health problems in general wards (Talley et al., 1990) and on interdisciplinary cooperation (Fitt, 1983). Contact with specialist mental health services in A & E led to fewer A & E visits by people with mental health problems, but did not improve compliance with psychiatric appointments (Dyckman et al, 1999).

It was noteworthy that studies evaluating the outcomes of LMHS were fewer. Service users' views had not often been solicited in studies evaluating liaison

services, despite service user contact accounting invariably for the majority of the work of liaison professionals.

### **3.4 The Developing Role of Service User Experience at the Study Inception**

Prior to primary data collection and in considering the approach to data analysis the literature on the expectations, satisfaction and service user experiences of LMHS and LMHC were considered in the context of key theories and research relating to this area.

#### ***3.4.1 Measuring Service User Expectations of and Satisfaction with Services***

According to Locker & Dunt (1978), obtaining the opinion of service users concerning their care, ,remains important on three counts:

- i) for evaluation purposes,
- ii) as an outcome variable and
- iii) as an indicator for change or improvement.

##### ***3.4.1.1 The measurement of service user satisfaction***

The focus of the studies identified up to 2000 which reported service user data regarding LMHC, all attempted to identify satisfaction levels with the LMHS. The first major interest in measuring satisfaction related to how satisfaction influences compliance, and therefore, through improving service user satisfaction, treatment compliance was improved (Williams, 1994). Ley



(1988) also proposed a cognitive model linking satisfaction directly to treatment compliance. Williams (1994) identified four models of satisfaction in relating satisfaction to: i) attributes of care, ii) service users' desires, iii) rewards and iv) social comparisons. Measurement of service user satisfaction with health services has been a long-standing research interest; however more recently it has been suggested that service user expectations of health care services were in some way linked to satisfaction (Williams, 1994; Thomas & Bond, 1996; Staniszewska & Ahmed, 1998; Staniszewska & Ahmed, 1999).

It is worth noting that the term satisfaction was not used by Staniszewska and Ahmed (1999) in their evaluation of a cardiac service, because their review of the literature led them to identify that service users did not relate well to the word. The study found that service users did not spontaneously use the term 'satisfaction' in evaluating their care, but did evaluate care based upon their expectations. Expectations were found not to be static and were influenced by the service users' hospital experience (Staniszewska & Ahmed, 1998; Staniszewska & Ahmed, 1999).

Thus the 'measurement' of satisfaction has been a contentious area and as yet there remains no definitive method of measuring satisfaction that demonstrated validity and reliability across services or disciplines (Aharony & Strasser, 1993; Williams, 1994; Staniszewska & Ahmed, 1998; Staniszewska & Ahmed, 1999). Most researchers agreed that a lack of an accepted definition, or underlying theory of satisfaction, led to a plethora of research

regarding satisfaction, the outcome of which led to no consensus view (Williams, 1994; Thomas & Bond, 1996; Staniszewska & Ahmed, 1999; Staniszewska & Henderson, 2004).

Avis et al (1995) argued that satisfaction surveys did not address areas such as choice, redress and patient safety and they also lacked attention to psychosocial needs and outcomes. In contrast to earlier work by Donabedian (1980), Avis et al (1995) advocated a return to more detailed qualitative interviewing techniques in order to explore the meaning of satisfaction from the perspective of the service user rather than the professional. This would require a more detailed understanding of the experiences of service users of LMHC.

#### *3.4.1.2 Service evaluation*

More recently Staniszewska & Henderson (2004; 2005) argued that evaluation was a far more appropriate term and an approach to use, especially in ascertaining the negative experiences that service users may have of services. Staniszewska and Henderson (2004) also reported that service users found it difficult to express negative opinions. In their study they found that criticism was embedded deep in analysed text, expressed through preferences, given with provisos or expressed by proxy through carers. It was further argued that an understanding of social and political pressures on the health care system and inherent issues of power influenced service users' ability to criticise services (Staniszewska & Henderson, 2005). This suggested that high levels of satisfaction, as expressed through the

survey designs used in the identified studies of service user satisfaction, may in fact report inflated levels of satisfaction.

Both Aharony and Strasser (1993) and Staniszewska and Ahmed (1999) recommended further research into the concepts of 'satisfaction' and 'expectations' through use of more exploratory approach that focused on the process of patient evaluation and people's experience of services. They argued that this, in turn, would assist in the development of a theoretical underpinning to service evaluation (Aharony & Strasser, 1993; Staniszewska & Ahmed, 1999; Staniszewska & Henderson, 2005). The literature review (as reported here) was unable to ascertain that such research had been completed in the context of LMHC.

#### *3.4.1.3 Service User Expectations and Experience*

Up to 2000 the field of LMHC in the UK had yet to explore service users' experiences and expectations of the service provided, either using measures predetermined by professionals or developed by service users. Donabedian (1980) argued that quality and satisfaction with a service might not be the same from the perspective of the professional offering the service and the user receiving the service. No evidence base existed to determine how service users might evaluate LMHC and therefore what expectations they might have which might then lead to an ability to measure satisfaction. Furthermore the literature identified that the measurement of satisfaction was not a process that was in itself clearly defined within healthcare. Within mental health the potential for a mismatch between professional and service

user views had been identified by Anthony & Crawford (2000). Donabedian's (1980) opinion was that overall satisfaction required a combination of both professional and service user views. Yet by 2000, the author found no evidence available to determine how service users' experienced LMHC, therefore to impose a predetermined set of satisfaction questions upon service users of LMHC was premature, because as yet there has been no evidence to outline what mattered to the users of LMHS.

### **3.5 Taking Stock – summarising the case for the current research study**

The preceding literature review led the author to conclude that having examined the literature in relation to the structure process and outcome of LMHS, it was apparent that further work needed to be undertaken to understand how service users experience liaison mental health services. There was an absence of UK research exploring the experience of people who had used liaison mental health care. Only two published studies were identified which considered service users measures of LMHC but these did not explore the experience in depth and sought to identify only service users' satisfaction with services as an outcome measure (Locker & Dunt, 1978), primarily through the use of survey methods using measures predetermined by the professionals delivering LMHC. Without a knowledge of how service users experienced LMHS it seemed somewhat premature to undertake surveys of satisfaction because what mattered to service users had yet to be identified and therefore what constructs to measure to determine satisfaction with LMHC were not defined. Therefore it was argued that it was important to

understand the service user experience of LMHC and that these experiences should impact upon service provision and evaluation. This understanding had yet to be described and in developing LMHS consideration needed to be given as to how best to meet the needs of service users, based on understanding how they experienced current service provision.

### **3.6 Updating the Literature Review: 2000 - 2013**

The following sections proceed to report an update from 2000 to 2013 of the preceding literature review on the structure process and outcome of LMHC. There then follows a section which updates the ever changing policy context of LMHC. Sections then follow which cover a review of the literature on service users' experience of healthcare, which is another area of expansion over the study period. In order to contextualise the development of service user experience literature this section begins with an update on the policy context of service user experience in healthcare. With a continuing dearth of literature, specifically relating to service user experiences of LMHC, the literature review of service user experience was broadened to consider the service user experience of mental health care. Particular attention is given to the literature on self-harm because the experiences of this group are well documented and show the closest match to the service users involved in this study. The majority of research into the experiences of those who self-harm is related to their experiences in the ED and this represents an important aspect of LMHC provision. Aspects of the wider service user experience of

healthcare are also touched upon, utilising the meta-synthesis completed by Entwistle et al (2012).

The aspect of the literature review which covers the service user literature was undertaken after secondary analysis of the interview data was completed. It is appropriate to conduct a two stage literature review when adopting a grounded theory approach to data analysis (Dunne, 2011). Within the grounded theory tradition it is argued that when analysing data using a constant comparative method undertaking a detailed literature review of the question that the study seeks to address prior to data analysis can affect the ability of the researcher to fully and openly view, understand and interpret the data. It is argued that knowing what researchers have previously discovered and theorised regarding studies in the same or similar areas will restrict the researcher in looking only for those themes and ideas that are already available and can prevent the researcher from finding new and alternative understandings that may emerge from the data during the process of coding and theorising (Strauss & Corbin, 1990; Dunne, 2011). This is not to say that this is the only approach and the case has been made for the acceptability of undertaking a substantive literature review of the area to be studied prior to completing the data analysis (Dunne, 2011). The methodology (chapter 4) considers this point in more depth.

### **3.7 Updated Review of the Structure Process and Outcome of Liaison Mental Health Services 2000 – 2013**

The aim of this second stage literature review of studies reporting upon the structure process and outcome of LMHS is to update the initial literature review of the structure process and outcome of liaison mental health services completed in 2001. The initial literature review served to utilise the available published and grey literature in order to identify the current evidence base for liaison mental health services, thus setting the context in which this study was undertaken and the data were collected. It is necessary to provide a further updated critical review of the literature in this area before presenting the secondary analysis of the interview data.

#### ***3.7.1 Process for updating the literature review of the structure, process and outcome of LMHC 2000 - 2013***

A multiple database search was completed utilising the OVID platform. The databases included were: Embase, Medline, Evidence Based Medicine Reviews (which incorporates (ACP Journal Club, Database of Abstracts of Reviews of Effects (DARE), Cochrane Central Register of Controlled Trials, Health Technology Assessment, Cochrane Database of Systematic Reviews, National Health Service Economic Evaluation, Cochrane Methodology Register), OVID Nursing Full Text Plus, and Social Policy and Practice.

The search filter applied was identical to that used in the first review:

((mental and health) or psychiatry and liaison and evaluation).

The full search is reproduced in appendix 2.

Limits applied to the search were:

Limits: 2000-Jan 2013, English Language, Human.

Searching multiple data bases simultaneously naturally provides numerous duplicates. After duplicates were removed the search yielded 250 records. All of the 250 records were considered by the author and the inclusion and exclusion criteria agreed for the first review were again applied.

#### *3.7.1.1 Inclusion criteria*

1. Empirical literature giving information regarding the provision of liaison mental health services.
2. Liaison mental health services operating within Accident & Emergency.
3. Liaison mental health services operating within at least two different specialities.



4. Both qualitative and quantitative studies and descriptions of service provision.
5. Services that comprised a single discipline or multidisciplinary.
6. Review Papers synthesising empirical research.

#### 3.7.1.2 *Exclusion criteria*

1. Original empirical research prior to 2000.
2. Literature regarding treatment options for clinical work within liaison mental health services.
3. Literature not available in the English language.
4. Single speciality services, for example, a liaison service provided solely to an oncology unit.
5. Services covering only deliberate self-harm presentations.

Additional exclusion criteria were applied:

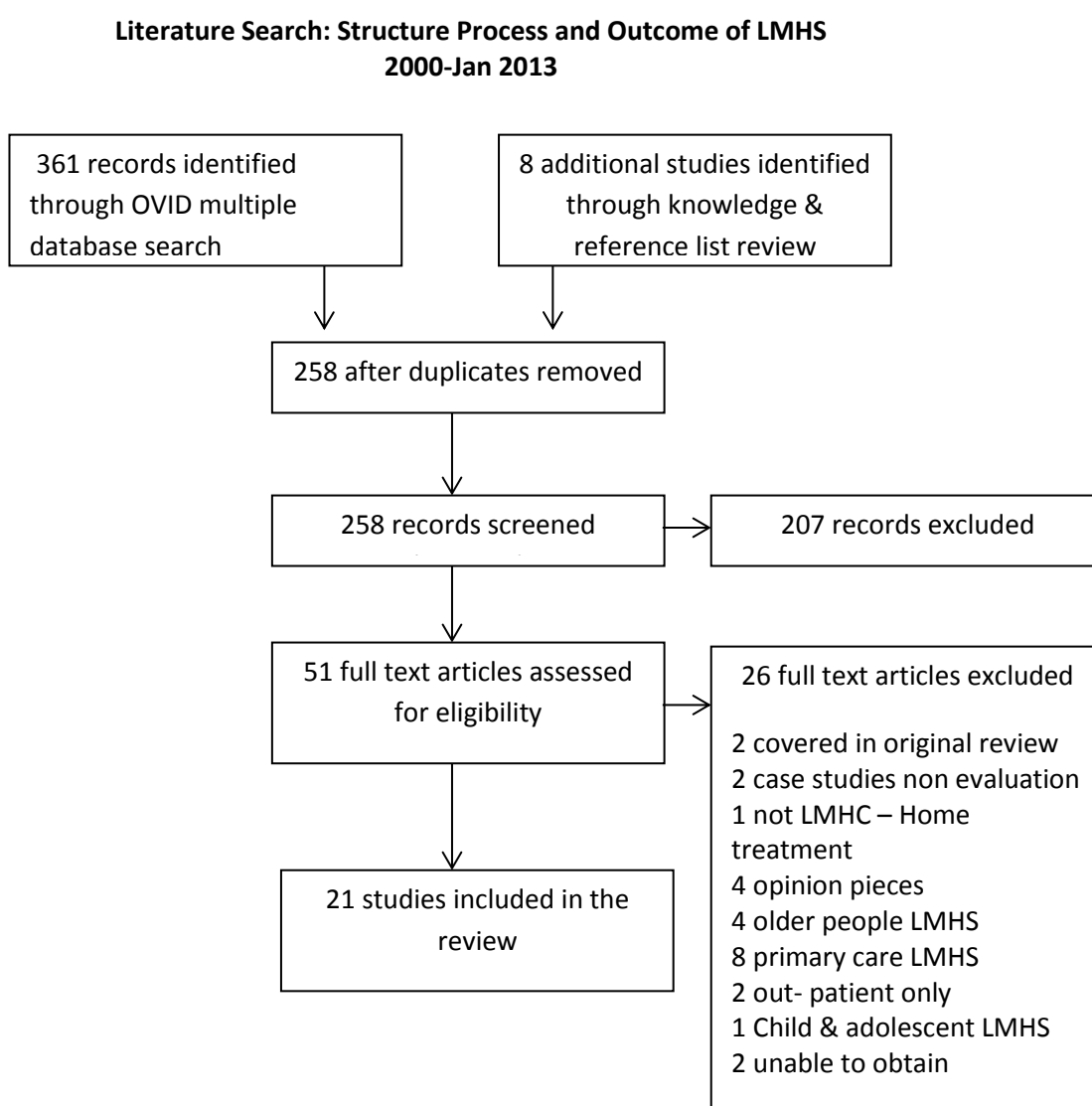
6. Literature reporting on LMHS to primary care or out-patients departments only.
7. Literature reporting only LMHS for child and adolescent or older adults (65+) only.

These additions were required because the review sought to consider literature relevant to adult LMHS within the general hospital setting and since the first review there had been a growth in publications specific to these developing areas of LMHC, which are beyond the scope of this study.

The reference lists of identified articles were explored for relevant studies and the author's knowledge of the field of LMHC led to the identification of a

number of studies published via sources not included in standard data base searches for research publications, for example the Centre for Mental Health.

An omission from the earlier systematic review was the recording of a flow chart outlining the application of the eligibility criteria this is presented below (Figure 3.1).



**Figure 3.1: Flow Diagram for eligibility criteria for the review of the Structure process and outcome of LMHS 2000 - 2013**

### **3.7.2 *Liaison Mental Health Services reported in the literature***

From the UK, seven new studies were included (Callaghan et al, 2001; Callaghan et al, 2002; Ruddy & House, 2003; Bennewith et al, 2004; Eales et al, 2006; Parsonage & Fossey 2011; Parsonage et al 2012). Two USA studies were identified (Diefenbacher & Strain, 2002; Yakimo et al, 2004), ten from Australia (Wand & Happell, 2001; Happell & Sharrock, 2002; Sharrock & Happell, 2002; Wynaden et al, 2003; Wand, 2004; Webster & Harrison, 2004; Sharrock et al 2006; Devasagayam & Clarke, 2008; Sharrock et al, 2008; Judd et al, 2010). One study from Canada (Brinkman et al, 2009) and one from Iran (Arbabi et al, 2012) were also included.

One study, reported by Yakimo et al (2004) was a review of the outcomes of psychiatric consultation liaison nursing at a similar time to the completion of the original literature review for this study, as a consequence many of the same papers are considered, the review appears to include papers published up until 2002 and therefore incorporates some of those included here (e.g. Happell & Sharrock, 2002).

Yakimo et al (2004) focused only on outcomes, considering cost outcomes, patient, family and staff satisfaction, changes in patient clinical status and changes in perceived work environment, although only studies of staff satisfaction were identified. It is unclear what strategy was used to search for

the literature. However the studies incorporated appear to be comprehensive. The review concluded that services needed to move to more outcomes focused evaluations by first identifying what matters in terms of outcomes to patients, families and professional stakeholders. Yakimo et al (2004) conclude that outcome measures currently used were not incorporating the diversity of the LMH nurse intervention, do not incorporate control groups and measurement at a number of time points within the intervention and post intervention.

Descriptive studies included Callaghan et al (2001), Diefenbacher & Strain (2002), Ruddy & House (2003), Webster and Harrison (2004), Devasagayam & Clarke (2008), Judd et al 2010 Arbabi et al (2012). Evaluative studies included Wand and Happell (2001), Callaghan et al (2002), Happell and Sharrock (2002), Wynaden et al (2003), Bennewith et al (2004), Wand (2004) Eales et al (2006), Sharrock et al (2006), Brinkman et al (2009) Parsonage & Fossey (2011), Parsonage et al (2012). Brinkman et al (2009) evaluated the satisfaction of professional stakeholders with a Canadian rural nursing LMHS. A qualitative evaluation of stakeholders views of a LMHS was reported by Eales et al (2006) using a thematic analysis of 47 interviews with service users and professional stakeholders. Wynaden et al (2003) reported a qualitative thematic analysis of eleven interviews with ED night staff following a three month pilot of a four days per week night time ED mental health triage consultancy service. Happell and Sharrock (2002) undertook focus groups to evaluate the role of a LMH nurse role in a general hospital.

Sharrock et al (2006) evaluated the addition of a LMH nurse to a general hospital, descriptive statistics of the nurses' activities are reported and the staff attitudes towards mental health patients before and eight months after the introduction of the role were compared. Focus groups were held with 25 staff to determine the impact of the LMHN role. Wand and Happell (2001) and Wand (2004) reported on two studies of a LMH nurse provision to the ED, firstly as a three month pilot and secondly as a one year evaluation. Callaghan et al (2002) and Callaghan et al (2001) reported on the characteristics of an ED and general hospital and ED only LMHS in inner city London respectively. Callaghan et al (2002) presented an evaluation from the service user perspective.

Data collection for the descriptive and evaluative studies ranged from six months to ten years, focus groups, semi-structured interviews, structured questionnaires and review of normally collected audit data were utilised as data collection methods. Quantitative measures almost invariably were reported as descriptive statistics only and qualitative data utilised content analysis to theme the data. Diefenbacher and Strain (2002) however provided a ten year prospective audit of a USA LMHS.

### **3.7.3 *Liaison Mental Health Service Structure***

An Australian survey of consultation-liaison nurses (Sharrock et al, 2008) identified the majority of nurses working with general hospital wards (77%),

the ED (71%) or both (57%). Forty eight per cent worked only with older adults (65 plus). Interestingly 41% offered treatment to hospital staff who had mental health issues. The majority worked within teams and with other professionals primarily psychiatrists; they primarily worked on a single site however coverage of up to 27 sites was reported by one LMHN. High numbers of sites covered by one LMHN was associated with community and rural roles rather than inner city provision. The majority (89%) assessed and treated in-patients and 57% covered the out-patients department. Referral routes to nurses were informal and came from a variety of professional groups rather than just nurses.

In individual studies the exact nature and staffing of the service was not always included however Webster and Harrison (2004) presented a brief description of an off-site LMHS comprising of nurses, social workers and occupational therapists. The service could respond within 30 minutes to the general hospital including the ED, however they noted that this was not always possible because the team covered community emergencies as well as the ED and general hospital wards. The meeting of attendance timeframes was not reported upon, therefore the frequency that responding to community emergencies impacted upon responses to the general hospital and ED emergencies is unclear. The team member responding to the general hospital also covered the community care provision, and they also identified a further role in the education of general hospital staff. It is not clear how this educational role would be accommodated within the remit to respond to urgent needs. This crisis team intervention did not include

psychiatrist input, which appears to come via an on-call registrar, who attends for example if admission is required. Whilst providing an overview of the staff profile and the provision the size of the hospital covered is not incorporated, nor the annual attendances via the ED, therefore comparison is difficult to other services, from the study high levels of job satisfaction were identified (91%) interesting, stimulating, challenging and autonomous were identified as defining the role in the qualitative feedback. Seventy one per cent of the nurses received clinical supervision but this was not considered satisfactory by the authors, all nurses should receive clinical supervision for their practice. Many of the respondents considered a post-registration qualification for LMH nurses appropriate, it was unclear if one was available. The later findings were presented by McNamara et al (2008) in a second paper covering the same overall study.

Wynaden et al (2003) reported on a nursing service offered four nights per week (Thursday to Sunday). The service offers triage and intervention for service users who presented to the ED with mental health issues. The aim of the service was to provide timely assessment and appropriate intervention in order to reduce waiting time and offer better risk management, and appropriate onward referral. Sharrock et al (2006) reported on the introduction of a LMH nurse into a previously mono-disciplinary psychiatrist LMHS, the hours of service were not provided. The annual admission rate to the hospital in Sharrock et al's (2006) study was 46,000. Wand (2004) and Wand and Happell (2001) report on a nurse LMHS in the ED only operating 9am to 5pm Monday to Friday. Callaghan et al (2001) and Callaghan et al

(2002) reported on a multi-disciplinary (psychiatrist, nurse and social worker) service operating 8am to 9pm Monday to Friday and 1pm to 9pm Saturday and Sunday and 24 hours 7 days per week respectively. Callaghan et al (2002) shows that the service audited earlier in Callaghan et al (2001) had developed from an extended hours to a 24 hours service. Arbabi et al (2012) reported on a psychiatrist and nursing service at two teaching hospitals in Iran the nursing role and hours of operation were not specified.

Ruddy and House (2003) undertook a postal survey of general hospital trusts to establish LMHS provision across the North East region of England. With a 100% response rate (n=36), 33 had a LMHS. Forty one per cent comprised nurses only, no service had psychology input. Twenty four per cent provided out-patient clinics. All covered working age adults, with 69% also covering older adult however the authors does not specify if the whole hospital, ED or both are included in the services. Services were not always based on site (61% off site). Disparity in provision was attributed to a lack of strategy for provision and not necessarily needs based provision. Concerns were expressed by the authors that not all services were multidisciplinary and not enough psychiatrist input was available to meet current guidelines (RCPsych, 1996; RCPsych & RCPhysicians; 2003). Judd et al (2010) offered data on the changes to a maternity hospital service over four years, staffing levels changed from one psychiatrist to a 4.8 whole time equivalent service operating 24 hours a day.



Overall service configurations appear diverse with no comparative model or pattern of provision emerging. Information was frequently only partially provided. There was a diversity of areas covered, again no single country presents studies for consistent service provision, making comparison difficult both nationally and internationally. Where information was provided it was clear that some services are offered over 24 hour periods 7 days per week, others over the 9am to 5pm and variations in extended hours. It is also notable that some services were clearly multi-disciplinary whereas as others were uni-disciplinary.

#### **3.7.4 *Process of Liaison Mental Health Services***

Reasons for referrals were reported in a number of studies, Webster and Harrison (2004) reported 406 referrals over a six month period, most frequently self-harm (41%). Other presentations included alcohol and drug problems (10%), depression (9.5%), aggression/ agitation (8.5%). Sharrock et al (2006) reported 179 referrals over one year (2000-2001). Nurses (45%) and medical staff (31%) were the primary referrers. Judd et al (2010) reported 153 referrals rising to 247 per year for a 24 hour maternity hospital service. It would have been helpful to know the referral rate in order to make judgements about what initially appears to be a low referral rate for the size and 24 hour function of the team in the study by Judd et al (2010).

Sharrock et al (2006) reported that 54% of their referrals were men, the mean age of referrals was 47 (range 18-91). Callaghan et al (2001) reported

949 referrals over a fourteen month period with a mean age of 33, the ethnicity of referrals was 44% UK non- white and 21% UK white, other groups included Asian, Irish and white European. In Callaghan et al's (2001) study the gender balance was 50% men, 49% women, the most frequent diagnosis was depression (12%) followed by dual diagnosis (8%) and when drawn together alcohol and substance misuse represented 14%. Emergency referrals were more likely to have a diagnosis of schizophrenia whereas urgent referrals were more likely to have a diagnosis of depression. Forty eight per cent of referrals in Callaghan et al's (2001) study are new referrals previously unknown to the LMHS. In Callaghan et al's (2002) following study when the service had become 24 hours and also covered in-patient wards referrals had altered, slightly, a greater proportion were men (57%) and 58% described themselves as white and 17% as Bangladeshi.

Arbabi et al (2012) showed a higher proportion of female referrals (54.6%) than male in their 503 patient Iranian study; the most frequent diagnosis was depression (24%), similar findings to studies from other countries. Arabi et al also noted that ambiguous referrals were least likely to receive a diagnosis and that adjustment disorder and cognitive impairment showed the longest length of stay before referral, which they hypothesise could be due to the challenges in identification for the treating physician. Devasagayam and Clarke (2008) saw the mean age of referrals, not surprisingly increase from 46 years to 59 years when older adult provision was incorporated into the psychiatrist led LMHS. There was also a resultant 59% increase in referrals but no staffing increase. As with most liaison services Judd et al (2010)

report depression as their primary referral group (49%), however within this maternity hospital service past psychiatric history is the next most frequent reason for referral (48%). This is a legitimate reason for referral in the maternity setting but is unlikely to be an accepted reason in the general hospital setting without current symptoms.

Callaghan et al (2002) utilised the HoNOS to identify the presentation of the clients with 56% having relationship difficulties, 22% reporting positive symptoms of schizophrenia and 19% were severely depressed. The most frequent ICD-10 diagnosis remained (compared to Callaghan et al, 2001) depression (31%), followed by substance misuse (13%). Sharrock and Happell (2002) report self-harm (20%) as their most frequent reason for referral, followed by anger and hostility (13%). The most common diagnosis following assessment is mood disorder (30%).

Diefenbacher and Strain (2002) used different measures in their ten year prospective audit to Callaghan et al (2002); this length of data collection offers unique insights over time for a single USA service. Reason for referral remained static over time most frequently depression, behaviour management, capacity assistance and suicide risk assessment. Diagnosis following assessment was again static with the exception of a statistically significant decrease in adjustment with depression and a statistically significant increase in major depressive disorder. The authors were unclear as to the reason for this change. Most frequent diagnosis was organic

disorder (40%) followed by depressive disorder (28%). Depression was the most common diagnosis in the majority of other studies reported here.

Webster and Harrison (2004) identified the triage nurse in the ED as the primary referrer, as did Callaghan et al (2001). Nursing staff represented the primary referrers in Sharrock et al's (2006) study (45%) and that of Sharrock and Happell (2002), however in Sharrock and Happell's case nurses at a ward management level are specifically identified. The LMH nurse also fielded 102 requests for informal support rather than direct patient contact again primarily from nurses. Callaghan et al (2001) reported the most popular referral time as between 1pm and 2pm. Sixty seven per cent of referrals are classed as urgent, to be seen within 1 hour, the average waiting time was ten minutes.

Devasagayam and Clarke (2008) saw referrals decrease but not stop when a change in role led to less direct case finding by the psychiatrist on a particular unit, they concluded that without 'active case finding' referrals will decrease but there will remain a group of patients who will be referred to the LMHS. There was a statistically significant increase in the referrals needing a same day as opposed to routine assessment / intervention but the urgent referrals (within 1 hour) did not significantly increase over time in Diefenbacher & Strain's 10 year study (2002), perhaps reflecting the increased dependency of hospital in-patients over time.

Webster and Harrison (2004) identify that from the 406 referrals to their off-site LMHS 57% received no further intervention, twenty per cent were admitted to mental health in-patient services and only 3.9% were referred back to their GP. Webster and Harrison (2004) noted that the lack of referral back to the GP is very concerning because in the Australian health care system the GP is the primary care provider. It is not noted if the GP would be automatically notified of the ED visit despite not receiving information directly from the LMHS.

### ***3.7.5 Outcomes of Liaison Mental Health Services***

Wand and Happell (2001) reported on an evaluation of providing mental health nursing expertise in the ED in Australia. The site was an inner city hospital and no mental health services appeared to have been available on site prior to the pilot project. In order to understand the needs of the nurses in the ED for specialist mental health nursing input two focus groups were conducted. ED nurses reported a number of concerns related to patients with mental health problems, most related to their levels of skills and knowledge, including not having the repertoire of terminology to communicate with the psychiatric registrar, the need for increased knowledge in risk assessment, management of disturbed behaviour and psychopharmacology. Nurses also identified long waits for psychiatric assessment following medical clearance for physical treatment and the need for protocols and practice guidelines in areas such as rapid tranquilisation. Following the focus groups a larger group

of medical and nursing staff (n=53) completed a questionnaire to assess their ability in relation to 20 skills relevant to working with mental health patients. Statements with high scores (above 20% of respondents) were reported: feeling not at all competent were triage, differentiating intoxication from psychosis, communication skills for dealing with aggression and liaising with case managers of mental health patients.

The questionnaire used was previously used by Gillette et al (1996). Following a pilot of two and a half months the staff were asked to evaluate new mental health liaison nursing role. Within the very short timescale the nurses reported valuing the resource the LMH nurse offered and the informal and formal training provided. Both nurses and medical staff identified the LMH nurse had intervened to assess patients and therefore reduced waiting, and they made the connection to cost savings, although not evidence to substantiate this is provided. Better responses to challenging presentations, better communication with community services were also identified as improved. MH nursing intervention to the ED appear to have had a noticeable impact in a short space of time to improve the competence of ED staff through teaching, the quality and timeliness of assessment for mental health patients, through direct intervention and therefore allowed ED staff to focus more on patients with physical health needs.

A further one year evaluation of the same service was reported by Wand (2004) again with positive feedback from staff. The most striking aspect of

the 2001-2002 year long evaluation is the reality that with a 9-5 Monday to Friday service three quarters of the mental health presentations to the ED were outside of those hours and were therefore not seen by the LMH nurse. It is therefore not surprising that the most frequent improvement request from ED staff was to have a 24 hour 7 days per week service. Effectiveness of the LMH Nurse was rated at 3.7 for Assessment of mental state, risk assessment and 3.6 for working with self-harm patients (maximum score =4). The lowest score was 3.2 for formal education (Wand, 2004).

Bennewith et al's (2004) study is not primarily reporting on LMHS, however it is noticeable for its report of the comparison of hospitals with and without LMHS and the proportion of service users who self-harm who received a psychosocial assessment. No significant improvements in levels of psychosocial assessment were identified where a LMHS existed compared to where one was absent. Rates of hospital admission and mental health follow-up also showed no difference in comparisons between LMHS and non LMHS ED's. When one considers that if a LMHS operates 9am to 5pm weekdays it is possible that 75% of those who attend are not seen (Wand, 2004) this may account for why no impact on rates of psychosocial assessment was achieved (Bennewith et al, 2004). These studies were not completed in comparable healthcare situations (one is UK based and one is Australian) therefore this would need to be reviewed at a national level to see if this hypothesis were correct.

### **3.7.6 UK Economic evaluation of Liaison Mental Health Services**

Parsonage and Fossey (2011) reported the first economic evaluation of implementation of one UK based service. The Rapid Assessment Interface and Discharge (RAID) service, which replaced an existing unspecified LMHS with a 24/7 service offered to all patients aged 16 and over. The RAID model is currently being implemented at a number of sites across the UK and as such is the current model of preference for commissioners, therefore the two published reports on this service model (Parsonage & Fossey, 2011; Parsonage et al, 2012) are given in-depth consideration below. The economic evaluation (Parsonage & Fossey 2011) was based on a review of an internal service evaluation which incorporated an economic evaluation. Data were collected from December 2009 to July 2010. Details of the staffing of the service were not provided and the references from the service are as yet unpublished. This makes any comparison between services problematic. The service responded to A&E (ED) referrals within one hour, meeting this target for all but 6.8% of referrals and responding to the wards within 24 hours, again meeting this target for all but 10.2% of referrals. The service did not appear to cover out-patient services.

Overall the economic evaluation suggested that the service made savings in the region of £3.5 million per year, primarily from reduced length of stay and reduced readmission rates and most specifically for the over 65 age group. The other noticeable and very interesting finding of the economic evaluation is that the greatest saving was apparent not from direct intervention by the service but through both formal and informal education of the general



hospital ward staff. Unfortunately it is unclear how and exactly what was delivered by the RAID team in terms of education so the results could not be replicated as the model and intervention are unclear in this publication (Parsonage & Fossey 2011). The baseline service was costed at £0.6 million and the additional service provision to offer the RAID service added a further £0.8 million to the cost of LMHS provision. The cost benefit ratio of 4:1 is calculated only on the additional cost of the service, not the whole cost of the service, therefore a hospital of the same size with no current provision could potentially see the cost benefit reduced as the overall cost of the LMHS would need to be included, the UK still has hospitals that do not benefit from an on-site LMHS of any kind.

The most frequent reason for referral to the RAID service was given as DSH (27.6%), depression (16.2%), cognitive impairment (13.6%) and alcohol dependence (12.5%), reflecting similar findings in other reviewed studies. The average number of referrals per month over the data collection period was 250 with 41% from the ED, 34% from the wards and 26% from the regional poisons unit. The fact that the service was based in the hospital that provides the regional poisons unit is likely to skew the reason for referral when compared to hospitals that do not have such provision. Hospitals without such provision may also see greater savings if their ward referrals represent a higher proportion of overall referrals and if those referrals were from the 65 plus age group. Parsonage and Fossey (2011) noted that with the current data collection account was only possible for some potential cost savings, namely those to the NHS. Savings to social care and savings

resulting from diversion from the ED were not considered and required a change in method to incorporate follow-up post discharge of case matched patients; this was likely to require an entirely prospective design. Parsonage and Fossey also accepted that there was no account of any increased costs to community mental health services such as home treatment teams and CMHT or to primary care services such as GPs in the economic evaluation. Greater costs might also be worth considering in relation to social care provision if service users are diverted away from health services. However this study by Parsonage and Fossey (2011) was one of the first UK attempts to establish cost benefit for LMHS and as such represented an important publication. This report went on to form the basis of the economic evaluation in the report by Parsonage et al (2012), *Liaison Psychiatry in the Modern NHS*.

The Centre for Mental Health report *Economic Evaluation of a Liaison Psychiatry Service*, compiled by Parsonage and Fossey (2011), was based on data from two groups of patients. Firstly a retrospective (pre-RAID) control group, aged over 16 admitted with a mental health issue (during December 2008 and July 2009). The second, intervention group, consisted of all such admissions (between December 2009 and July 2010). The intervention group thereafter was comprised of two sub-groups: (i) the RAID sub-group, consisting of all those patients in the intervention group who were referred to and directly managed by the RAID service; and (ii) the RAID-influence sub-group, covering all other patients in the intervention group, who were not

directly seen but where the RAID team provided training and support to the acute hospital staff who managed these patients.

There are a number of problems with such a design which strictly speaking does not conform to the standards set for quality economic evaluations (Drummond et al 2005, Schulz et al 2010). Firstly the design lacks any form of randomisation which is one of the main benefits of a Randomised Controlled Trial (RCT) and the best means to reduce bias by maximising the likelihood that variables are distributed randomly and most likely therefore, evenly amongst the two trial arms. In the case of Parsonage and Fossey (2011) this is not the case with the study also being susceptible to the weakness of before and after methodology design. Reliance on before and after designs can have a particular effect of 'sensitizing' those taking part in the study, such that any after testing would be affected. A particular concern thereafter is that any effects arising can be mistaken for the effect of the intervention when this may not be the case (Robson, 2002). The lack in randomisation to address variables being distributed evenly does remain a weakness and a concern for unaddressed potential bias.

In terms of a hierarchy of experimental design research RCTs would be considered as strong and towards the top end of such a hierarchy. RCTs are carefully designed experiments, in which equivalent control and intervention arms are used to test an intervention. They are frequently used in the testing of the efficacy or effectiveness of new healthcare interventions, ensuring a

balance between groups in terms of size and patient characteristics (Altman & Bland, 2005). The randomisation process is important as, when performed well, it eliminates selection bias by balancing both known and unknown factors to the assigned two arms of the study (Moher et al, 2010). In contrast quasi-experimental case control and/or before or after studies would be considered as being of moderate quality (Greenhalgh, 2010).

Concerning the potential impact of liaison psychiatry on NHS costs, the review cites meta-analysis of nearly 100 relevant research studies. These papers found that psychological interventions for patients with physical conditions being treated in acute hospitals and similar settings reduce health care costs per patient by about 20% on average (Chiles et al., 1999). This led the authors to argue that savings on this scale could translate to potential cost reductions of around £1.2 billion a year at the national level, or £5 million a year for a typical 500-bed general hospital. They further cited an example of an economic analysis in which a programme of screening and early treatment for postnatal depression could be good value for money even in the short term, because of the positive effects on mothers' health and economic activity (Bauer et al., 2011). However the problem with these projections, as reasonable as many of the assumptions in them are, is that it cannot be confidently argued what measurable specific contribution LMHC itself could make towards any savings.

A similar critique can be made of the authors' (Parsonage et al 2012) enthusiastic efforts to make a case for service expansion and to demonstrate the clinical and economic impact of LMHS. The authors cite a study undertaken at Hull Royal Infirmary (Lynch & Greaves, 2000) over a 6-month period when 40 regular attendees presented 475 times, with numerous admissions resulting. Regular attendees account for a large proportion of the ED workload. Parsonage et al (2012) suggest that improved management of these patients, via LMHC, may be beneficial, however this is based on an assumption that LMHC can 'cost shift' or in other words divert these patients away from the services they currently use. This is problematic as at no point can this be more than an estimate outside a properly conducted cost effectiveness study designed around a randomised control trial (RCT). Furthermore cost saving does have to consider the costs of setting of a psychiatric liaison service as well and cost saving does not necessarily mean cost effective in the true sense of being cost effective in a statistically significant way. These are important and crucial differences to consider and can make the differences between some cost differences between different treatment options just being marginal or really making a difference in the way resources are used at a national level. Therefore it is arguable as to whether the case for cost effectiveness of LMHS has as yet been conclusively made and further studies with more robust designs will be required to substantiate the initial findings of Fossey and Parsonage (2011) and Parsonage et al (2012).

### **3.7.7 Professional stakeholder and service user evaluation of Liaison Mental Health Services**

In the review of services a greater evidence of evaluation from the professional stakeholder perspective was evident than in the original literature review up to 2000.

Wynaden et al (2003) interviewed eleven staff to evaluate a night time LMHS to an ED. The study established that waiting times had been reduced, this finding was cross checked with statistical data and the average response time had decreased from 235 minutes to 36 minutes, this prompt assessment reduced pressure on the ED staff. Findings also indicated that patients were cared for from arrival rather than having to wait overnight for assessment prior to the LMHS intervention. Availability of specialist input had increased. The ED staff reported lower levels of violence and aggression during the pilot of the LMHS. As a consequence staff desired the service be expanded to cover a 24 hour seven day week. The involvement of the mental health nurse had helped staff learn how to assess and treat mental health service users more effectively and confidently. Happell and Sharrock (2002) reported four themes: making contact, helping staff, implementing strategies and utilising attributes, in their staff evaluation of a LMH nurse role. Data were collected from focus groups with 17 staff. The response was overwhelmingly positive; no negatives were raised. Availability i.e. being overstretched and not being able to get people to take the required action were the only limitations. It is unclear from the paper if this is a review of a single PCLN or a number and to what extent the personal attributes of the nurse therefore affect the perception of the overall PCLN role. Sharrock and

Happell (2002) report 90% satisfaction with a LMHN service with staff identifying it as timely, accessible, well documented and professional.

An Australian study (Melbourne) surveyed 136 patients who used a psychiatric service in the ED over a six month period during 1999 (Summers & Happell, 2003). The survey responses were remarkably positive, with over 90% of patients responded positively to each question. Questions elicited information about receiving information, professional manner of staff, and listening to problems. However, almost 50% of those seen during the data collection period were excluded. Ninety-four patients in total were excluded from the interviews because the psychiatric liaison staff who assessed them in the ED deemed that they should not be interviewed because “*further contact would be non-therapeutic and destabilizing*” (Summers & Happell, 2003 pp353). Information regarding the characteristics of these ‘excluded’ patients is not given, even though such data were collected. Summers and Happell (2003) concluded from comments made during the telephone interviews about the characteristics of psychiatric staff, such as being easy to talk to and providing information and explanations contributed to the patient satisfaction. Difficulties for patients related primarily to the non-mental health aspects of the ED, such as unhelpful comments from the ED staff and the lengthy waiting times, which caused anxiety for patients and families. They recommended that those with mental health issues required prioritisation in line with that for those needing other specialist interventions in the ED for physical health conditions.

Eales et al (2006) utilised semi structured interviews with a combination of professional, primarily ED nurses, and service users to consider what was important to both groups of stakeholders, the results were grouped into three themes namely “practicalities” which included waiting times, the “staff profile” which included the appreciation of the mental health knowledge of the LMH team and the ability of the LMHS to offer service users new insights into their problems. In the theme “receiving the service” service users and professional stakeholders acknowledged that the LMH team could offer service users more time to talk than ED staff could provide. They concluded that the themes could be used to consider how services were delivered. This was the first published UK paper to focus on service users’ experiences using a qualitative method, however these findings were presented in combination with stakeholder interviews and the service user findings are not reported separately.

Brinkman et al (2009) created a questionnaire based on the job description of the LMH nurse and professional literature describing LMHC. One hundred and sixteen responses from professional stakeholders were received. In all domains including fostering positive working relationships, raising awareness of mental health issues and contributing to better health outcomes for patients the role was perceived positively. This was the first Canadian evaluation of this kind of service; the need for service user evaluation was



identified, positive response led to the development of seven further similar roles.

Sharrock et al (2006) described the nurses attending their focus groups as positive in the language they used to discuss the LMHN role. Allied health professionals were more ambivalent and concerned about role clarity. LMH psychiatrists felt the LMH nurse helped to assist general nurses to understand the psychiatric assessments and translate their recommendations into action, thus offering general nurses support that was not previously available. Overall professional stakeholders report satisfaction with LMHS, this is understandable when they compared the provision to a time before the existence of such a service. It was unclear if these levels of satisfaction can be maintained over time.

Callaghan et al (2002) reported seventeen services users' strengths and weaknesses of a LMHS, strengths included short waits, time to talk, and privacy in the ED. They also reported a 27% (n=71) response rate to a postal satisfaction questionnaire sent to all patients seen over a one year period. Whilst the qualitative data had produced mixed experiences the postal questionnaire produced high levels of satisfaction. The questionnaire used was an amended version of the Verona Service Satisfaction Scale (VSSS) (Ruggeri & Dall'Agnola, 1993). The professional skills and interventions of the LMH team were rated more highly than the accessibility and relatives involvement sections of the questionnaire. This is the only study identified

reporting service user satisfaction with a LMHS. Response rates to satisfaction surveys varied greatly from 27% for Callaghan et al's service user postal questionnaire to the 100% response rates to Wand and Happell's (2001) professional stakeholder evaluation of a LMHN role.

### ***3.7.8 Key Findings from the Literature Review 2000-2013***

Over a ten year period the length of stay for patients halved in the study period from 25.7 days to 13.4 days, which reflects changes in the approach to care in the hospital setting (Diefenbacher & Strain, 2002). Sharrock et al's (2006) LMH nurse service offered a general education programme to 531 staff over the course of the year evaluation. A survey of nurses' attitudes to mental illness found no significant differences in attitude before the service began and after eight months. It is not clear if these nurses had attended the education or interacted with the LMH nurse and the samples at the two measurement points appear to be different. Callaghan et al (2001) in collecting audit data on 'non-clinical' activity illustrate the work of the LMHS aside from direct patient contact with the service receiving 949 referrals to see patients directly but also 1213 requests for other forms of assistance such as advice and support in managing mental health issues (n=890). Sharrock and Happell (2002) identified 1323 separate interventions by the LMH nurse in resolving 90 referrals. This included breaking down each intervention into aspects such as, work with the family, as well as the patient and the professional. A case study would have helped the reader to understand the application of the numerous activities to the 90 patients.

It is striking how many studies offer only limited or no information at all, on the nature of the service provided in terms of professional roles, staffing levels, and hours of operation, thus making comparisons between services and studies very difficult, if not impossible. Furthermore, the addition of information regarding the size of the hospital or ED is also often not available which again impacts on the ability to make comparisons, referral rates is an alternative approach and some studies include this. This lack of information has implications in implementing any recommendations from studies because it is difficult to gauge if they are applicable to a LMHS as it is currently structured.

The challenges of measuring liaison mental health interventions when these interventions comprise a single visit amongst the work of a multi-disciplinary team over a number of hours, days or weeks may account for the lack of evaluative studies of the overall impact of LMHS (Parsonage et al, 2012). Whether quantitative or qualitative in design the available studies describe and evaluate only single services. The lack of consistent data on the service profile, hours of operation and hospital size make undertaking a meta-synthesis of quantitative data impossible. Meta-synthesis of qualitative data from service user and professional stakeholders may be beneficial in order to create a broader model of the impact and value of LMHS to all groups of stakeholders.

Descriptive statistics in the evaluative studies, for example, Diefenbacher & Strain (2002), Judd et al (2010) and Sharrock & Happell (2002), identify differing statistics for the reason for referral compared to the diagnosis made by the LMHS, however no discussion of this is had within any of the papers, it would be very interesting to know if the perceptions of referrers of the need of the patient is borne out by the assessment of the specialist LMHS and whether one of the foci of educational work for LMHS is related to addressing any misperceptions on the part of the referrer.

Much of the recent literature, particularly from Australia, focuses on the role of the nurse in LMHC. The roles identified are clearly advanced practice roles, requiring for example independent decision making, clinical leadership and provision of education. The value of LMH nurses appears to lie in this advanced practice and this needs to be retained as LMHN develops, ensuring that the right quality of nursing staff are recruited to LMHC roles. Extending services and providing additional services can lead to a dilution of models and this needs to be guarded against.

Evidence reported suggests, although not by any means robustly, that providing a LMHS of any kind will improve the competence of staff to identify, assess and manage mental health presentations in the general hospital. Services should be robustly evaluated, incorporating the views of service users and leading to clear service development outcomes. The educational

impact of LMHS matters to general hospital staff and services must develop with capacity to provide education within the general hospital.

There is a need for national studies which compare models of service and evaluate their impact within the general hospital on a number of levels, including economic impact, impact on the morbidity of mental health conditions, general hospital staffs competency with mental health issues and the improvement of the service user experience. Within the UK context the expansion of the RAID model must be evaluated to establish if this is the most appropriate service model, comparisons with other models should be undertaken. The robust design of quantitative research must incorporate before and after designs, ideally RCT's and all should incorporate prospective collection of data. This review highlights that data collection inconsistencies exist and future research must eliminate these inconsistencies to enable comparisons.

### ***3.8 Policy and Guidance within Liaison Mental health Care (LMHC)***

#### ***2002 to 2013***

Over the ten years since the inception of this study and twelve years since the original data collection was completed, there has been increasing interest and range of publications regarding LMHC and liaison psychiatry. There is, overall, an improving level of professional organisation within the field of LMHC, namely the Royal College of Psychiatrists developments which have built upon the inception of the Faculty status of psychiatric liaison in 1997. Of

these developments perhaps most significant was the creation of the Psychiatric Liaison Accreditation Network established in 2008. The Psychiatric Liaison Accreditation Network (PLAN) is a not for profit accreditation scheme run by the Royal College of Psychiatrist's College Centre for Quality Improvement. PLAN is designed to identify the quality of service provision and services can gain a quality approval rating through a process of peer and self-review which is presented to the Accreditation Committee (Palmer et al, 2010).

The PLAN scheme draws together representative from a variety of Royal Colleges and amongst these organisations there has been no shortage of recognition of the need for more organised and securely commissioned LMHS in every hospital environment (Academy of Medical Royal Colleges (AoMRC), 2008a; JCPMH, 2012). The AoMRC identified in its report and background document (AoMRC, 2008a; AoMRC, 2008b) that when patients were admitted to non-mental health settings due to mental health issues or with concurrent mental health issues those issues should receive the same level of high quality response that any other condition would receive. In needing to state this they implied that this was not the case in 2008. Parsonage et al ( 2012) identified that this need for equity of care remained unmet, because not all hospitals had a designated LMHS covering all ages and all areas of the acute hospital (Parsonage et al, 2012). Overall the AoMRC recommended this could best be achieved by acute trusts directly commissioning LMHS and that these services should be subject to current quality standards applied to all other speciality service provision. The LMHS

commissioned should be a generic service able to offer high quality assessment, treatment and follow-up across all age groups (JCPMH, 2012) and encompassing learning disabilities (AoMRC, 2008a). This reference to learning disabilities appeared to be the first time that this need was integrated into the agenda for LMHS provision. The AoMRC report was a position statement, whereas Parsonage et al (2012) were offering an economic evaluation and review of research evidence on health outcomes, however both documents came to the same conclusions, that LMHS should be available to all hospitals, covering all mental health issues and learning disabilities and available to all age groups.

### ***3.8.1 Funding Liaison Mental Health Services***

Many liaison services within the UK London region, where the author is based, identify tenuous and often highly complex forms of funding with recently set up services being provided with at best funding for 1 year or even in some cases funding for 3 months at a time (London Wide Liaison Nurses Special Interest Group, 2013). Providing an effective service and recruiting the highly motivated and skilled staff needed to fulfil the requirements for competent liaison practitioners, including the competencies identified and set out within the Liaison Mental Health Nursing Competency Document (Hart & Eales, 2004) is, under such circumstances extremely difficult. In the recent economic evaluation of liaison psychiatry services by Parsonage et al (2012) the piecemeal development and insecure funding of LMHC was identified. Parsonage et al concurred with the author's experience in finding that many liaison services had developed due to the

personal intervention of enthusiastic individuals either working within the field of LMHC or working with in the field of general practice or acute medicine. It was not until the most recent Government documents on mental health provision, No Health Without Mental Health (HM Government, 2011) that the status of LMHC i.e. the provision of mental health across the dichotomy of mind and body gained a new level of significance at a policy level and as a consequence the work of Parsonage et al (2012) became even more poignant. In the preceding ten years a number of organisations had attempted to intervene to raise the profile and importance of LMHC or psychiatric liaison as it is also known, however often their attempts to raise the profile of LMHC have seemed to go unheeded (AoMRC, 2008a; AoMRC, 2008b). Where services have been developed tenuous funding arrangements do not suggest that the commitment is for the long term.

### ***3.8.2 Evidence Based Liaison Mental Health Care***

The systematic review of the international literature has also identified a paucity of high quality research both of a quantitative and qualitative nature for the structure process and outcome of LMHS. The greatest advances have been in the evidence base for specific interventions, usually this research is of a quantitative nature and provides evidence for a specific treatment option for a specific condition (reviews of specific interventions have been offered by Guthrie, 2006; Parsonage et al, 2012; Ruddy & House, 2005). The overarching evidence base for value in terms of both health outcomes and reduction in costs is as Parsonage et al (2012) identified still



lacking. In their 2012 economic evaluation they were forced to hypothesise and generalise about potential cost benefits of LMHC.

*“For a typical general hospital of 500 beds, this corresponds to a cost of around £25 million a year [for co-morbid mental health problems]. While clearly subject to a wide margin of error ...”*

(Parsonage et al, 2012 pp11)

The report by Parsonage et al (2012) is an important report to consider and review due to it being a most recent publication but also as it sets out the findings of a study of liaison psychiatry services commissioned by the NHS. The report seeks to identify and describe how liaison psychiatry can most effectively contribute to the QIPP (Quality, Innovation, Productivity and Prevention) agenda, by providing services for patients with co-morbid physical and mental health problems to not only improve health outcomes but also reduce the overall costs of health care. As the report explains the QIPP agenda<sup>2</sup> requires the NHS to make efficiency savings of up to £20 billion by 2014/15 while maintaining standards and the quality of care. In the case of LMHC the argument is made that standards need to improve not remain static which presents even greater challenges.

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<sup>2</sup> NHS Improvement EQIPP:  
<http://www.improvement.nhs.uk/Default.aspx?alias=www.improvement.nhs.uk/qipp> [accessed 19-06-13]

The report's authors explain that the study was commissioned as a follow-up to a short report published in 2011 which highlighted the results of an economic evaluation into RAID LMHS at Birmingham City Hospital (Parsonage & Fossey, 2011). From this work the authors argued there was a strong business case for the RAID model, based in the main on the ability of the service to reduce acute inpatient bed use by shortening lengths of stay and reducing rates of re-admission, particularly so among older patients. Based on this analysis, the RAID service was subsequently identified in the NHS Operating Framework for 2012/13 as an example of good practice to support delivery of the QIPP challenge, stating:

*“Innovative service models such as the RAID 24/7 psychiatric liaison service have been shown to generate significant cost savings and health improvements”*

(DH, 2011b pp22).

A number of new liaison psychiatry services based on the RAID model are now under development around the UK. Therefore a question then arises as to whether this was robust decision making made on the best available economic data. This is especially so as a search for literature on economic evaluations of the liaison psychiatry model are absent. It would appear therefore that a national expansion of services based on the RAID model has been undertaken on the basis of the evidence provided by this one 2011 study from the Centre for Mental Health (Parsonage & Fossey, 2011). The quality of these two reports has already been considered in more depth in

the updated structure process and outcome section (Section 3.7.5), however to summarise it is arguable as to whether the case for cost effectiveness of LMHS has as yet been conclusively made and further studies with more robust designs will be required to substantiate the initial findings of Parsonage and Fossey (2011) and Parsonage et al (2012).

### **3.8.3 Commissioning Liaison Mental Health Care**

The commissioning impetus for more robust mental health care provision within emergency care and acute care settings has gathered pace, noticeably since 2011, with the addition of the RAID model to the *2012/13 NHS Operating Framework* (DH, 2011b) and recently updated commissioning guidance (JCPMH, 2012). This appears to have corresponded with the UK government's mental health strategy, *No Health Without Mental Health* (HM Government, 2011). The commissioning documents from the JCPMH (2012) and Fernandes's (2011) commissioning guidance for GP Clinical Commissioning Groups (CCGs) drew primarily upon the work of the AoMRC (2008a; 2008b) and earlier policy documents such as the Royal College of Psychiatrists Council Report CR118 – *Psychiatric Services to A&E Departments* (RCPsych, 2004). The case being made within the commissioning guidelines for integrated mental health provision in the form of LMHS, which should be made available across both acute hospital in-patient and the ED. Fernandes (2011) acknowledged the ED as the place many people present with mental health issues and that rather than attempt to sign post those patients away from the ED that provision, at all EDs, should be made for their timely assessment. Both Fernandes (2011)

and the JCPMH (2012) argued the case for provision of LMHS in acute in-patient services across all hospitals as the primary means of meeting the government strategy of providing good mental health care within non-mental health settings. The Fernandes document provides a comprehensive guidance regarding mental health service provision for Clinical Commissioning Groups (CCG's) and weaves together the importance of substantive, well provisioned LMHS throughout for achieving effective mental health care. Yet, the full impact of these commissioning guidelines are yet to be felt, as changes to commissioning processes and the inception of GP Commissioning Consortia are only just taking effect within the NHS (Newbigging & Heginbotham, 2010).

#### ***3.8.4 Self-harm and Suicide Prevention***

In September 2012 the latest suicide prevention strategy was launched (DH, 2012). The report acknowledged there are issues outstanding in terms of the quality and equity of assessment and support offered in the ED to people who self-harm, a theme which has continued over time (DH, 1999; NICE, 2004). Furthermore this strategy also identified that staff in the ED have poor attitudes to those who self-harm, often due to lack of training in mental health. Despite the identification that there are still issues of concern in the quality and equity of assessment and support offered in the ED to people who self-harm, the role of LMHC was not acknowledged within the suicide prevention strategy. This may be, in part, because the research by Bennewith et al, (2004) cited in the strategy was unable to find a significant difference between the number of service users receiving a psychosocial

assessment where a designated LMHS existed and those where there was no LMHS. This finding does not suggest that LMHS were effective in improving self-harm assessment rates in the ED.

Comment was also made in the suicide prevention strategy that the environment for those people who are attending ED in a distressed state could be improved (DH, 2012). Communication between the ED and primary care was also identified as important in terms of working to reduce suicide rates in the high risk group of people who self-harm (DH, 2012). LMHS will inevitably play a role in the improvement of services for people who self-harm if the commitments recommended by Parsonage et al (2012) and DH (2011b) for 24 hour LMHS to all hospitals, were implemented. The author would argue LMHS could play a key role in ensuring that people who self-harm are accommodated appropriately (safely and respectfully) and are offered effective assessment and treatment when they present to the ED. Again in this recent UK government policy documents (DH, 2012), the LMHS role is not identified as central to meeting such expectations. One issue is perhaps the ongoing paucity of evidence, but there also remains no level of commitment in terms of research funding streams to further evaluate service provision as it currently exists, nor to develop and evaluate LMHC. This lack of targeted research is possibly why the author has continued to find research is being carried out by the enthusiastic few, yet without robust funding any evaluation studies will not reach high quality and high impact levels required to prove or disprove the worth of LMHS in order to influence future policy and service innovation.

### **3.8.5 Recommendations from Professional ‘Experts’**

Parsonage et al's (2012) report was significant in making positive recommendations, drawing on both research evidence and anecdotal evidence, to recommend that all hospitals should have a liaison service with a first line approach that encompasses all ages and medical wards and the ED. The limitations of the work by Parsonage et al have already been identified (section 3.7.5). Notwithstanding this, their recommendations for direct patient contact that is high impact, i.e. complex cases and capacity building within non mental health staff through training and education is the key work stream for LMHS identified by Parsonage et al (2012). Brunero and Lamont (2010) and Patel et al (2009) set out examples of capacity building in the context of support for general hospital nurses to improve in assessment of suicide risk. Looking forward Parsonage et al (2012) suggested that liaison services will be required more in the community in the context of the government agenda to move care of chronic long term conditions (LTC) into the primary care sector and community provision.

There are some obvious differences between the findings of Parsonage et al (2012) and previously issued guidance on service provision. This may be in part because economic outcome measures form part of Parsonage et al's work. Aitken (2007) developed a *Policy Implementation Guide for Liaison Psychiatry and Psychological Medicine in the General Hospital* and in this he identified the provision of LMHS as including the direct assessment of all

those referred from within the general hospital and furthermore identified that LMHC included the support of service users who had 'impaired mental well-being'; in using this term he was acknowledging that much of the work of a LMHS, when assessing everyone referred, encompassed many people who would not reach the threshold for a clinical diagnosis of a mental illness but rather would be presenting in psychological distress, this resonates with the authors experience in the general hospital setting. Parsonage et al (2012) make the case that this is not a cost effective way to provision LMHS and that services should assess and treat only those with the most complex presentations. Linking LMHS provision to economic viability is clearly important however as Lyons et al (2009) and the NICE Patient Experiences in Adult Mental Health Clinical Guidelines (NICE, 2011) identified service users do need to have access to services before psychological distress reaches the threshold for services such as home treatment and in-patient admission and measuring the effect of services that intervene early to offer support and sign-post service users is challenging, because the measurement relies on prediction of what might have occurred if the support was not provided (measurement of a non-event). If Parsonage et al's (2012) recommendations were to be adopted the role of LMHS would change dramatically, current service provision focuses on high levels of direct patient contact. Bower and Gask (2002) in reviewing the early evolution of primary care LMHC identified that what can be evidenced from the minimal research that is available is often very far removed from the service provision adopted and sustained in practice.

### **3.8.6 Overview of policy developments**

From study inception to submission the interest and quality of policy, guidance and reports into LMHC has increased and improved. However, national guidance such as the current Government Mental Health strategy (HM Government, 2011) attest LMHC has yet to become integrated within the acute hospital setting. There is a clear conflict between the tentative evidence base for only offering high impact work and education (Parsonage et al, 2012) and the good practice guidance for commissioning (Fernandes, 2011; JCPMH, 2012), policy implementation (Aitken, 2007) and patient experiences (NICE, 2011). Further research and evaluation is required to add to the evidence base for the effectiveness of LMHS provision. There remains a debate about the function and role of LMHC. Adoption of a more integrated approach to mental and physical health care is currently recommended which will place LMHC higher up the agenda in non-mental health settings. The current interest in ensuring all hospitals have a LMHS offers the opportunity to evaluate services as they develop.

## **3.9 Policy Context Relating to Service User Experiences in Health Care**

Over the course of the study the shape of public and patient involvement with health care has developed. Quantitative national in-patient and community mental health surveys are undertaken, latterly via the Care Quality Commission (CQC) which gather annual information regarding service users experiences of mental health care. These reports are quantitative and cover core aspects of care, for example as defined via the Care Programme



Approach (DH, 2008) and include questions to ascertain if current mental health service users are aware of who their care coordinator is and whether they have access to emergency support via telephone 24 hours a day. Individual mental health trusts can access data related to their own service users experience and make comparisons between their service user responses and the national data. This kind of information gives a very broad brush set of information and can guide trusts in understanding where their services may be improving or alternatively are failing to meet core standards, however these data do not elaborate on how services can be improved from the service user perspective. Changes to the legislative landscape for health and social care have occurred during this study and in particular Section 242 of the NHS Act (2006) (DH, 2007) is relevant in so much as it strengthened the requirements on all levels of the NHS to involve and consult the public and patients in the development and alteration of health care provision. The DH briefing (DH, 2007) identifies public and patient involvement at all levels from the involvement of representative groups though to the individual and considers their involvement a “must do”. NHS Boards (the organisational level oversight of NHS Trusts) were identified as needing to improve the means by which they gather, review and act upon patient or service user feedback on services; as many boards are only responding to the information received via national surveys and complaints (Rowntree 2008).

Towards the latter part of the study the DH (2011a) produced a framework of elements critical to the patient's NHS experience. These elements are outlined in figure 3.2.

Elements Critical to the Patient Experience of NHS services
<ul style="list-style-type: none"> <li>• Respect for patient centred values, preferences and expressed needs</li> </ul>
<ul style="list-style-type: none"> <li>• Coordination and integration of care</li> </ul>
<ul style="list-style-type: none"> <li>• Information, communication and education</li> </ul>
<ul style="list-style-type: none"> <li>• Physical comfort</li> </ul>
<ul style="list-style-type: none"> <li>• Emotional support</li> </ul>
<ul style="list-style-type: none"> <li>• Welcoming and involving family and friends</li> </ul>
<ul style="list-style-type: none"> <li>• Transition and continuity</li> </ul>
<ul style="list-style-type: none"> <li>• Access to care</li> </ul>

**Figure 3.2: NHS Patient Experience Framework (DH, 2011a)**

This framework sets out eight guiding principles or elements of the patient experience. The UK Government expects all services to be measured for their engagement with this framework as part of the QIPP<sup>3</sup> agenda for quality improvement within the NHS. The implementation of Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMS), the terms used for service user measurements within the QIPP

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<sup>3</sup> NHS Improvement EQIPP:  
<http://www.improvement.nhs.uk/Default.aspx?alias=www.improvement.nhs.uk/qipp> [accessed 19-06-13]

agenda have yet to impact directly on upon LMHC, however it is likely that measures of this nature will be required in the future.

The Patient Experience Framework draws on the patient-centred care work of Gerteis et al (1993) which identified seven aspects of patient centred care. These principles were drawn from a variety of research sources. McCormack et al (2012) cautioned that the adoption of the theories of person and patient centred care into policy and guidelines has a tendency to miss out the key facet of the needs of not just the patient but also of the staff in order to be able to deliver the principles of patient or person-centred care. McCormack et al argued that consideration of all those involved in care in order to implement the model is a prerequisite. This is the foundation of the work of Nolan et al, (2006) in developing an expanded relationship-centred care model, which overtly encompasses recognition of needs and rights not just for the patient but for all the players in the delivery of care including the carers and family and also the professional care givers.

At the level of service provision those LMHS affiliated to the PLAN programme (Palmer et al, (2010) are required to obtain service user and carer feedback on services to gain accreditation, however evidence from sitting on the accreditation panel over three years (2009 - 2013) indicate that all service assessed show low levels of feedback obtained and report struggling to gain service user feedback.

In 2011 NICE produced guidelines on *Service User Experience in Adult Mental Health Services* (NICE, 2011) and in 2012 this was followed by guidance on the *Patient Experience in Adult NHS Services*. These represent two more sets of guidance on the service user experience. There is little commonality between the two NICE guidelines with only four out of a total set of fourteen to fifteen statements that map across both guidelines. The commonalities are: dignity and respect, understanding treatment options, shared decision making and continuity of care. It is unclear if both documents should be adopted for LMHC, given that there is overlap. Comparing the NICE Guidelines with the Patient Experience Framework (DH, 2011a) again there is overlap however areas such transition between settings and services and access to care do not appear in the NICE Guidelines. There is clearly a current drive in relation to ensuring that service user experience is monitored and improved within NHS services. In the plethora of documents that exist it may be difficult for the clinicians to ensure that they attend to the relevant issues for those using their own services, especially for services such as LMHC where obtaining patients views is challenging.

### **3.10 Service user experience of health care provision**

The research and information available from the service user perspective is vast and quite disparate, however there is no in-depth research available into LMHC from the service user perspective. Therefore this literature review section provides primarily an overview of the areas of research that have been considered during the period that the discussion was under

development. Namely the personal accounts of mental health care, the literature on healthcare experiences of those that present with self-harm and latterly touches upon research which attempts to draw together and summarise service user experience of healthcare research.

### **3.10.1 Service User Experience of Liaison Mental Health Care**

In reviewing service provision to make recommendations for the future shape of LMHC Parsonage et al (2012) were unable to identify any research into the views of liaison mental health service users. As part of their work they visited 5 LMHS in the UK and were often able to obtain local data to help them make their recommendations however in respect of Patient Reported Experience Measures (PREMs) they came to the following conclusion,

*“Collecting and working with the experiences of patients was not a universal feature of the services we visited. Good practice in service delivery and engaged and informed commissioning should drive this important mechanism for informing improvement.”*

(Parsonage et al 2012 pp45)

With little research into the service users experiences of LMHC it is not clear what should be measured and how. This literature review has earlier identified that measurement of satisfaction with LMHS through questionnaires is theoretically problematic and furthermore we do not as yet

know what matters to service users so cannot ask them to evaluate LMHS using measures set by professionals (section 3.4.1). There is a need to understand in-depth what is important to service users when they come into contact with LMHS before being able to consider the appropriate demands that commissioners should place on services for evaluating LMHS from the service user perspective.

### ***3.10.2 Service User Experience of Mental Health Care***

There exists an extensive body of information available in many formats that provides personal accounts of mental ill health, experiences of mental health services and treatment approaches. These literature exist in published forms such as anthologies (Read & Reynolds, 1996), magazines such as Open Mind<sup>4</sup> and One on Four<sup>5</sup> and also in on-line formats, such as the Health Talk On-line website<sup>6</sup>, the value of which and the development of the themes which it uses to structure the information is described by Ziebland & Herxheimer (2008). In formulating the structure of the website they concluded that service users require assistance to navigate through the experience of illness and healthcare and find value in being able to access the experiences of other service users. The Health Talk On-line website is a vast resource and covers the mental illnesses depression and schizophrenia. In both the written service user literature and the on-line resource references to general hospital experiences tend to focus on ED attendance and usually

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<sup>4</sup> Open Mind - the publication of the charitable mental health charity Mind, <http://www.mind.org.uk/>, published until 2012.

<sup>5</sup> <http://www.oneinfourmag.org/>

<sup>6</sup> <http://www.healthtalkonline.org/>

refer to the experience with the general hospital staff without making reference to LMHC.

### ***3.10.3 The research into service user discourse regarding mental health services.***

Having established in previous sections that literature pertaining to service users experience of LMHC is lacking (section 3.7.7) and in order to help in the conceptualisation of the study findings the research literature from related groups of service users, (namely those who have self-harmed and have experience of presenting to the ED and also those who have used crisis resolution or home treatment) were considered, These service user groups might well also access LMHS provision. Summaries of the broader literature on overall service user experience of healthcare were also considered and are included here. The review is limited to most recent available publications (2000 -2013).

### ***3.10.4 Service users who have self-harmed***

In a 2007 study of service users who had self-harmed and presented to the emergency department Palmer et al noted that admission to general hospital for self-harm is in the top 5 reasons for admission to the ED. Palmer et al (2007) undertook a survey of 509 people in the UK, exploring their experiences of the ED following self-harm, information giving and communication are key themes in the work. The study was quantitative in design but also allowed for free text comments from service users. If service

users were not kept informed of the waiting in the ED they might choose to leave and take their own discharge before the outcome of any assessment was known. The opportunity to talk” was identified as a positive aspect of a full psychosocial assessment. Service users also accounted for a negative experience because their views were not taken in to account. The Palmer et al (2007) study includes single written statements which do not allow for the in depth understanding of the impact felt by the service user. The responses of the Better Services for People who Self Harm study conducted by Palmer et al (2007) has been the engagement of individual services to develop their specific responses to self-harm presentations in the ED.

Palmer et al's (2007) findings resonate with an earlier, much smaller, yet in-depth qualitative analysis of people who self-harm undertaken by Lindgren et al (2004). Lindgren et al (2004) identifies the positive impact of instilling 'hopefulness' within service users who have self-harmed. The nine women in their study had been in contact with in-patient or out-patient mental health services rather than the ED or LMHS. The service users identified positive experiences as those that fostered 'hopefulness' within them. The interactions with staff that were likely to instil a feeling of 'hopefulness' were those that gave the service user a sense that the staff had connected with them, that the staff believed the service user's feelings and that they (the service users) were understood. In a very recent paper, Parkes and Freshwater (2012) have also used a similar term - hope as a term to summarise their findings from interviews with women in forensic services who have self-harmed.



Parkes and Freshwater (2012) were carrying out interviews with the women who had experience of self-harm to understand how they chose to express their emotions, but data gathered also enabled them to look at what reduced the women's self-harm or harm to others. In the paper Parkes and Freshwater do not discuss why they chose the overall phrase of "journey from despair to hope" for the title of the paper and these terms were not discussed within the body of the paper. Service users in Lindgren et al's study (2004) also identified with the importance of a knowledge base in the area of self-harm .

Bryant and Beckett (2006) interviewed 24 service users about the experience in the ED following self-harm, these interviews were undertaken in the context of exploring if an advocacy service would benefit service users in the ED after self-harm, they concluded that advocacy could be a potential resource to service users and the healthcare professionals in the ED, this would primarily be in terms of being with the person and gathering information to help in decision making and from a professional point of view keeping an eye on the service user. Given that another piece of work from this team at Leeds identifies that twenty per cent of those who attend the ED with self-harm leave before assessment and treatment is complete (Horrocks et al, 2003) this seems very important.

The potential role of an advocate in the ED for self-harm service users was acknowledged as challenging and requiring effective training, support and supervision. It was also identified in the research that providing advocacy services would not negate the on-going need for training for ED staff aimed at improving attitudes, care and treatment for those who present to the ED with self-harm. Experiences of psychosocial assessment or LMHC was not considered in the study, perhaps the ED where the research took place did not have access to a LMHS. The interviewees in this study were exclusively those who have self-harmed and the report of the interviews focuses on the good and bad aspects of the experience in the ED, and there is no attempt to build an overall picture of the experience rather the analysis ends with the thematic deconstruction of the data. In the ED waiting times, being kept informed of what is happening and privacy are themes from the Bryant & Beckett (2006) study.

*“Information about the Emergency Department process should be communicated in a sensitive and timely fashion.”*

(Bryant & Beckett, 2006 pp11)

The inconsistency and inadequacy of action plans and outcomes was identified by service users and it was noted that service users lack the knowledge to know what is available. The thematic analysis of the data obtained by Bryant and Beckett (2006) used the same themes as those first identified in a study of 45 service users experiences of the A&E, again in

Leeds (Horrocks et al, 2005). The report did not appear to be published in the professional literature. Some of the themes have already been identified in discussing the work of Bryant and Becket (2006). Interestingly Horrocks et al's (2005) findings suggested that service users may be resistant or not receptive to talking. When presenting to the ED with self-harm, this again appears to be related to seeking support from the ED staff. Negative experiences and expressions of a negative attitude from the health care professionals, as described by the service users, were only cautiously accepted by Horrocks et al (2005), they considered that this may be part of the low self-esteem connected to presentations of self-harm.

In light of the importance place on gaining service users experiences it seems unfortunate to then theorise that they should be partly dismissed and excused. Services need to work to take these experiences into account and empathise with the presentation of the service user. Horrocks et al (2006) also identified that service users express concerns about returning to the situation that may have led to the self-harm, when being discharged from the ED direct to home. It is not clear from the study if the service users were offered any LMHC intervention during their visit.

A further key qualitative data set completed in the last 10 years is that contained in the NICE guidelines on the management of self-harm (NICE, 2004). In drafting the guidelines a literature review of nine reports and published papers was conducted along-side two focus groups with service

users who had attended the ED for self-harm. Within the summary of the literature review and the focus groups service users identified the ED as the least helpful place to seek support, the overall experiences were predominantly negative and they appeared to focus primarily on the experience of interactions with the ED staff rather than the experience of mental health care within the ED. Service users reported wanting to avoid using the ED and in extreme cases feeling that they would rather risk dying as a consequence of their injuries than attend the ED because they found the experience isolating and humiliating. The importance of being listened to and treated as an individual came through the data as having the potential to improve or lead to a satisfactory experience in the ED. However when service users were not listened to they were not honest about their feelings and reasons for self-harming, and therefore it could be extrapolated that any psychosocial assessment undertaken in this context would not form an accurate identification of the issues and could not therefore lead to appropriate care and treatment in the long term. Aspects of the environment including the need for privacy and calm without being isolated were evident in the NICE data, there was a perception that they were left to wait for unreasonably long periods, better information giving and being kept informed were identified as they were in the Bryant & Beckett study (2006). The NICE guidelines (NICE, 2004) concluded that presentations of self-harm could be challenging to ED health care professionals and were not the normal or standard presentations anticipated and because the harm was self-inflicted it challenged the professional understanding of why people seek help in the ED. Furthermore it was concluded that self-harm challenged what the staff

knew and what they were able to cope with; as a consequence the need for continued and on-going training to help ED staff understand why people self-harm was recommended. In reviewing the methodology of the literature reviewed and that of their own focus groups the NICE guidelines acknowledged that,

*“Few of the studies include interviews, and where they do, there is rarely any formal qualitative analysis that would allow more complex themes to emerge”*

(NICE, 2004 pp 85-86)

This criticism of the available literature lends credence to the current in-depth approach taken to the secondary analysis of data for the current study of service user experiences of LMHC and the overall aim of identifying an emergent theory to account for the service user experiences.

One other pertinent paper on service user mental health experiences is included here, Lyons et al (2009), which explores the experiences of those using crisis resolution services. It is argued that these service user experiences are relevant because this is a service often aligned with and sometimes integrated into LMHS provision, however not in the case of the current case study site. The study was also deemed relevant as it considered the build-up to the use of the crisis resolution service and few studies engage with this aspect of the service user situation, at the point of undertaking this literature review the issue of the build-up of a crisis had become an aspect of

the findings in the current data analysis. Lyons et al (2009) found that service users defined their crisis in terms of words such as “fear, desperation” and “distress” (Lyons et al, 2009 pp428) and also identified that they did not know where to turn. The service users interviewed for Lyons et al’s (2009) study went on to access crisis intervention services or in-patient admission. Lyons et al also identified the risk of harm as evident in the discourse of service users in crisis. Furthermore they identify that the intervention was not always available until there had been a significant escalation in the psychological distress that the service user could already identify. In considering service improvements service users in Lyons et al (2009) study wanted improvements to availability of staff and services in the ED. They also identified the need for better sign posting of service users about where, when and how to get help.

Lyons et al (2009) came to the conclusion that in the context of home treatment and in-patient care gate-keeping thresholds were too stringent and that services should be available for service users as the crisis develops and recommend that self-referral to crisis resolution services should be considered. It is possible that the ED presents a means of self-referral where the threshold is lower and therefore makes the service more accessible as psychological distress develops. Interestingly Lyons et al (2009) do not identify the ED as an option for meeting support needs of those service users who identify that they are in crisis but do not meet professional criteria, despite the fact that some service users interviewed had finally accessed

services through that route. This may be because service user reported experiences of the ED are negative (NICE, 2004).

Data available from studies identified here (NICE, 2004; Horrocks et al, 2005; Bryant & Beckett, 2006; Palmer et al, 2007; Lyons et al, 2009) suggest that a meta-synthesis of qualitative data from service users with experiences of mental health provision for crisis presentations, such as to the ED could be a future piece of work of value in attempting to draw together data from service users, incorporating but not limited to those who self-harm, in order to provide a broader set of findings from a wider data set.

### ***3.10.5 An overview of the literature on healthcare experiences***

Entwistle et al (2012) presented an interpretive synthesis of the literature on service users' experiences of healthcare in the broadest sense and offered a very useful overview of the status of literature on service user health care experiences. They have developed a conceptual map of the experiences that mattered to service users in their experience of healthcare events and the effects of these events. The process for development of the conceptual map sought to explore as many reported experiences as possible and did not exclude studies on the basis of rigorous study criteria nor did they seek to discount experiences if they were not noted repeatedly within the literature, this was a process of quantity over quality. Having identified a wealth of important factors through the meta synthesis of data from 77 papers and the experiences therein the authors initially attempted to apply the data to a

number of different pre-existing frameworks for patient experience, including the Six Senses Framework (Nolan et al, 2004) and the Institute of Medicine Quality of Care Framework (Institute of Medicine, 2001) (similar to that of the NHS Patient Experience Framework (DH, 2011a)). However they concluded that the synthesis had yielded experiences that did not create a good fit with the published frameworks. Utilising the structure, process and outcome model of Donabedian (1980), already adopted as a framework forming part of the preceding literature review, they present their own conceptual map, rather than attempt to list the factors identified, as by the authors own admission the map is “messy” the conceptual map is reproduced as figure 3.3.



# Health care delivery promotes my capability to be who I value being and do what I value doing

## Health care services and staff



Figure 3.3: Conceptual map of experiences of health care delivery



Entwistle et al (2012) argued that the inclusion of the service users' opinion regarding the characteristics or skills and competencies of staff is one reason why this map was unique and more comprehensive than previous frameworks. As already noted Donebedian (1980) acknowledged that the perspective of care, and satisfaction with it, may well be different from professional and service user perspectives. Representing aspects such as the opinion of service users about the appropriate skills and competencies of the professionals they meet, is relevant and does single this conceptual map out as a development in terms of frameworks. This literature review has already made the case that the service user voice and evaluation is considered as important now as any other measure of experience. Entwistle et al (2012) also argued that their map was more comprehensive, coming from an interpretive synthesis, led to wider coverage of interpersonal relationships experiences, than was found in individual studies or previous frameworks. The conceptual map was also presented as aspirational and positive in tone, wherever possible,

*“We wanted the map to present features of healthcare experience to be aspirational to, so we phrased most concepts positively.”*

(Entwistle et al, 2012 pp76)

The studies that came together to produce the conceptual map included experiences of maternity, respiratory, surgery palliative and mental health care, although a full list was not given.

By way of comparison it was pertinent to consider another systematic review of the overall patient experience literature, the review undertaken by Staniszewska et al (2011 cited in NICE 2012) and incorporated into the NICE full guideline on *Patient Experience in Adult NHS Services: Improving the experience of care for people using adult NHS services* (NICE 2012) was a recent detailed systematic review of the literature on patient experience of healthcare. This review did not appear to have been published within the research literature to date. The review was undertaken in pursuit of developing the NICE Quality statements for patient experience in adult healthcare. Patient experiences in three clinical areas, cancer, cardiovascular disease and diabetes are included, a less broad range than those utilised by Entwistle et al (2012).

As with the interpretive synthesis of Entwistle et al (2012) they aimed for data saturation in extracting data from the 171 research studies included. Staniszewska et al (2011) also accessed information from on-line resources, such as the already mentioned Health Talk On-line website, however in the overview of how themes were derived only the research studies are included. Similarly to Entwistle et al (2012) Staniszewska et al (2011) made an attempt to map their identified themes on to a pre-existing frameworks, namely the Institute of Medicine (IOM) Quality Framework (IOM, 2001). It is interesting to note that at the point this review was undertaken the NHS was between two frameworks, namely the IOM and the Picker Institute. The Picker Institute framework was used in publishing a final NHS Patient Experience Framework (DH, 2011a), it is therefore unfortunate that this review utilised

the former, rather than the later. Nevertheless these frameworks have similarities and as with the interpretive analysis of Entwistle et al (2012) the IOM framework was unable to cover all the themes identified and therefore Staniszewska et al (2011) formulated their own “Generic Patient Framework (NICE, 2012 pp147). The generic themes identified are reproduced below:

- *“Patient as active participant*
- *Responsiveness of services – an individual approach*
- *Lived experience*
- *Continuity of care and relationships*
- *Communication*
- *Information*
- *Support”*

Within the proposed Generic Patient Framework each theme is given a narrative description, for example the Support theme is described thus:

*“Different preferences for support: Support for self-care and individual coping strategies. Education. Need for emotional support, need for hope. Responsiveness of health care professionals to individual support needs (may vary according to gender, age, and ethnicity). Importance of peer-support, groups, voluntary organisations. Practical support. Family and friends support. Role of advocacy. Feeling over-protected, not wanting to be a burden. “*

(Staniszewska et al, 2011 pp147)

Staniszewska et al (2011) offered a review based on 171 studies over three conditions, Entwistle et al’s (2012) review was based on an undisclosed

number of studies, however the conditions included are wider. The approach taken to concluding the results is different in both papers and this makes a comparison of the findings challenging. Nevertheless both found that the adopted pre-existing quality frameworks were unable to accommodate the themes that they had drawn from their reviews. There is a developing plethora of frameworks and maps which attempt to articulate what matters to service users in their healthcare experience. The more recent ones are developed from systematic reviews of literature to create a more detailed outline, which as Entwistle et al (2012) admit can become messy. For those conditions or services where a vast array of research evidence exists regarding patient experiences the challenge that presents is how to utilise the research to improve the patient experience.

When considering the 171 research reports that were available to Staniszewska et al (2011) when reviewing data for only 3 health conditions it is not surprising that the Kings Fund (2011) stressed the recommendation to move from a research approach to exploring service users experiences to one of improvement action. However, what has been established within LMHC is the challenge to find one substantive research study into LMH service users experiences. Therefore it is argued that the Kings Fund position is not correct in the context of LMH service user experiences.

### **3.11 Liaison mental health care; increasing interest in service provision.**

At the inception of the study (2003) there was little research evidence to guide the development of specific service models (Callaghan et al, 2003). In the UK the *National Service Framework for Mental Health* (DH, 1999) identified the need to offer 24 hour access to care for those with mental health needs and this led to a rise in the provision of LMHS. However there was no government strategy to develop LMHC in all general hospital settings.

Over the course of the study the evidence base for specific interventions that could improve service users' mental health, particularly when it impacted upon their physical care needs improved (Ruddy & House, 2005; Guthrie, 2006). Alongside the evidence for the effectiveness of interventions there has been a rise in the body of literature that assessed the structure process and outcome of liaison mental health care, most noticeably with the first attempts to explore the economic value of LMHS in the UK (Parsonage & Fossey, 2011; Parsonage et al, 2012).

#### **3.11.1 Contemporary evolution of LMHS provision in the UK**

Further work is needed in the area of economic evaluation and the difficulties of identifying the impact of LMHC amongst all the services and interventions a patient will receive during an ED visit or in-patient stay presents an extreme challenge to more rigorous economic evaluation studies. With the growth in the evidence base LMHC remained an important aspect of general

hospital care, however without a government strategy to adopt LMHC and to direct service development services have emerged in a diverse and very individual way. Between 2000 and 2013 a number of organisations and Royal Colleges have attempted to articulate good practice in the provision of mental health care and to advise on standards for service provision (Aitken, 2007; AoMRC, 2008a) and also competencies for nursing staff (Hart & Eales, 2004). The development of guidance and policy in LMHC and provision has developed independently but simultaneously in the areas of working age adults and older adult care. The implementation of the Dementia Care Strategy (DH, 2009) has seen an increase in the focus on older adult LMHC. The current UK government mental health strategy, *No Health Without Mental Health* (HM Government, 2011) now attempts to bring mental health needs into greater focus across all healthcare settings and this has led to greater interest in directing commissioners as to how to commission LMHS in the general hospital setting (Fernandes, 2011; JCPMH, 2012), although commissioning guidelines did predate this government strategy (JCPMH, 2008).

Towards the conclusion of this study, alongside a developing policy interest in mental health across all settings including the general hospital, there was also a developing set of guidelines on the expectations for clinicians to meet in order to provide a good patient or service user experience. Although commonalities exist each set of guidelines is different and appears to have been developed independently.



### ***3.11.2 Evidence of service user experiences as an evaluation of LMHS provision***

What remains lacking in the published literature is specific evidence regarding the experience of service users of LMHC. In considering the evidence on the service user experience of LMHC there is only one obvious related body of literature to draw upon and this is for a single group, those who self-harm. Literature that explores the experience of service users who are seen by LMHS, other than those who self-harm does not appear to exist in a substantive form with only one published paper identified from a review of the last thirteen years (Eales et al, 2006) where experiences of service users are integrated with those of professional stakeholders. The paucity of literature on the experience of LMHC service users and the absence of published literature, despite a two phased literature search covering over twenty years of healthcare reform and modernisation that presents an in depth exploration of the service user experience is the rationale for this study.

The next chapter outlines the methodology used to undertake a grounded theory analysis to explore and theorise the experiences of service users of liaison mental health at an inner city case study site.



## **4 METHODOLOGY**

This chapter critically discusses the methodologies of secondary data analysis and grounded theory. The approach taken to address the research question was a qualitative one. The ontological underpinnings of the study are drawn from those of grounded theory and these are considered. Consideration of a semi-structured interview approach to data collection is offered in the context of constant comparative analysis, as adopted for the data analysis.

As outlined in the study background (Chapter 2) this study was based on a secondary analysis of data. The data used were collected using a semi-structured interview technique and primarily analysed to extrapolate service user satisfaction with a LMHS. It has already been argued (within the study rationale; refer again to section 2.6) that this primary analysis did not do justice to the richness of the data collected. Utilising the secondary data analysis methodology a more detailed and in depth analysis of the data was proposed using a constant comparative analysis which is an aspect of the grounded theory approach.

### **4.1 Secondary data analysis as a methodological approach**

Secondary data analysis is a deliberate research strategy that aims to make effective use of pre-existing data in order to reveal and investigate new questions and perspectives over time (Heaton, 2004; Long-Sutehall et al, 2010). This is in contrast to meta-analysis which aims to analyse (most often statistical) data existing across a group or broader scope of data derived

from a number of different studies to provide an aggregated overview. This study is therefore using existing qualitative data, collected as part of a mixed method study, and has identified service user interviews that provide existing material that was not included and underutilized in the primary research project for which they were gathered.

Greater emphasis on maximizing existing data, and formulating new understanding, has become an accepted approach, particularly accepted where the primary researcher is involved in re-analysing material with the intention of generating new ideas (Gladstone et al, 2007; Andrews et al, 2012). There remains confusion and some controversy over the issue of secondary data analysis, primarily where the original researcher is not involved in the secondary analysis and also where there is a lack of contextual data such as research diaries or journals because of the importance of context upon interpretation for many methods (Bishop, 2007; Long-Sutehall et al 2010). The author completed the original interviews and brings to the study a background in the field under study. Therefore the author is able to provide context and notes from the original data collection; thus it is argued that secondary data analysis is a relevant methodology for this study. Moore (2005, cited in Bishop 2007) also made the point that, dependent on the research questions and objectives, the data may require reframing in the current context. As part of the objective of the current study theorising from the data analysis includes the application of current socio-political contexts in the form of related policy and practice guidance to the findings. Despite some continued reservations secondary data analysis is a

developing field of qualitative inquiry with increasing support from funding bodies. Issues exist regarding the ethics of the use of data for secondary analysis and this is considered in the following methods chapter (chapter 5).

Heaton (2004) describes the type of analysis this study involves as 'supra analysis', where the terms of the primary study are 'transcended' with new methodological approaches and questions. To qualify as 'supra analysis' the research should also offer up new theoretical perspectives, as this study does through the use of a constant comparative analysis approach to secondary data analysis. Heaton does though make the point that where secondary analysis is adopted by the original researcher there is often a blurring of the boundaries between the initial and secondary analysis.

*“exploring a question which is closely related to the primary research ... the boundaries of secondary analysis and the primary research are often blurred.”*

(Heaton, 2004, pp 59).

The initial analysis of these data sought to examine the satisfaction of the service users with a LMHS. This study sought to expand that analysis to uncover the more detailed experiences and to attempt to extrapolate a theoretical understanding of what matters to service users when they require LMHC. Thus it is argued that the secondary data analysis builds upon the initial limited data analysis. Long-Sutehall et al (2010) provided an example of utilising secondary data and applying a grounded theory methodology,

they adopted this methodology arguing that their intended participants were hard to reach and therefore the utilisation of data collected for other studies in related areas were legitimate. It will be seen in the methods section that the service users of LMHC could be considered hard to reach, in so far as contact was attempted with many more people than were interviewed. However this argument was not the rationale for the current study, the richness of the data and the lack of an in-depth consideration of the experiences explored in the interviews and the responsibility of the researcher to explore these data in full was the rationale for the secondary data analysis methodology used in this study.

#### **4.2 Introduction to chosen methodological approach used for data analysis**

This section considers the application of a constant comparative analysis and the broader grounded theory methodological approach which informs the ontological principles applied to the study. The association between grounded theory and symbolic interactionism is discussed. The overall aim is to consider a methodological approach that enabled a rigorous process for working towards construction of new insight into service users' experiences of LMHS, grounded from and within the service user experience. In order to reach a deeper understanding of phenomena, when little research was available regarding the phenomena under investigation, an exploratory approach has provided considerable advancement in understanding complex human experiences (Strauss & Corbin, 1990; Silverman 2000). Creswell

(1998) asserted that the exploration of personal experiences has a long tradition in qualitative research (Creswell, 1998).

#### **4.2.1 *Grounded theory methodology***

Grounded theory is a qualitative research methodology first described in the 1960's by two sociologists (Glaser & Strauss, 1967) who raised awareness of the process of death and dying from the individual's perspective, influencing how professional carers perceived and approach the dying person. Drawing on the grounded theory approach for the data analysis the researcher seeks to understand the way that participants (i.e. service users) interact with a social phenomena (the LMHS). Through exploring the complexities of this social interaction, identification of the variance (i.e. the similarities and differences, in the way that the service users interact with the LMHS) data is deconstructed to be reconstructed in a synthesised way that enables new insights and provides potential for theoretical advancement. Wright (2007) describes the later element as the creative aspect where relationships between categories are developed, when compared to the more mechanical systemised initial coding aspects of data analysis.

Through exploration and an explanation of social interactions, as experienced through behaviours, the constant comparative analysis and the grounded theory methodology of which it forms part proves a useful

methodology for not only guiding the research process, but is also highly applicable to practice settings. For example, exploring the service users' understanding of and the meaning they place upon the interactions experienced. Having identified these interactions and their meanings the researcher can then look for broader application through exploring how the findings of these specific data relate to wider theories.

A grounded theory methodology suggests that the development of theory should emerge out of the data (i.e. be grounded within and from data) and not be influenced by contextual, prior knowledge or personal assumptions through, for example, any prior reading of what might be considered potentially relevant theories (Chenitz & Swanson, 1986; Strauss & Corbin, 1990; Corbin & Strauss, 2008). This requirement to 'bracket' any prior knowledge or preconceptions was a difficult task within this study. The researcher had experience as a liaison mental health practitioner, and works within the field of mental health education. Further reflection and an attempt to remain transparent in how decision making has, or has not been influenced are explored in chapter 5. A critical reflection on the application of one aspect of the grounded theory methodology within this particular context and study purpose is explored and exposed within that chapter.

The same principle of expecting the researcher to remain objective, applies to the importance of leaving an open mind regarding research findings in related areas. There is however the need to accept that even without



drawing upon already completed research the researcher comes with their own knowledge. This issue will be considered further in the later discussion of the insider-outsider debate in chapter 5. It is important to note however that following data analysis Corbin and Strauss (2008) identify the importance of not only grounding the development of theory within the data but also the wider context within which it exists and considering how processes may have changed over time.

There has been concern that there are as many approaches to grounded theory as there are authors (Dey, 1999). This has led to criticism that grounded theory methodology is unsystematic, leading to confusion and lack of credibility as a robust methodology (Thomas & James, 2006). Yet, this criticism can also be seen as a significant strength in terms of enabling broad application and demand for ongoing refinements through critical reflection, which it could be argued is the very nature of qualitative inquiry (Johnson et al 2001). This idea was shared by Charmaz (2000), who asserted that *'grounded theory can bridge traditional positivistic methods with interpretation'* (p 530) through providing a process for research that can provide a platform for more creative expression depending on the context. However, she did also provide a caveat that the results may then be a complex architecture that has potential to obscure experience. Charmaz, in 2000 offered an attempt to simplify grounded theory applying a constructivist approach, making clear links to the importance of meaning making, within a symbolic interactionist alignment.

Three key approaches to grounded theory have influenced the methodology of this study; adopting an aspect of the grounded theory approach the author identifies that the origins of the approach adopted lie in the grounded theory methodology of Glaser and Strauss (1967) and Glaser (1978). However a purist and original methodology is not laid claim to, only the aspect of constant comparative analysis is adopted within this study. Strauss chose to take the methodology in a slightly different direction by setting out, what critics and plaudits alike (Glaser, 1992; Johnson et al 2001; Charmaz, 2006) have identified as a more procedurally specific articulation of the methodology (Strauss & Corbin, 1990). Strauss and Corbin's methodology was refined in 1998 and again in 2008 (Corbin & Strauss, 2008). The grounded theory approach to data analysis adopted for this study was that of Strauss and Corbin's first edition of their *Basics of Qualitative Research* published in 1990. However the debates and discussions surrounding grounded theory have developed over the course of the study, namely with Corbin's third iteration of the text in 2008 where the ontological underpinnings of the approach are articulated and brought up to date, namely pragmatism and symbolic interactionism, these are discussed in the next section.

A further influence upon the later part of the study and the attempt to theorise about the data and subsequent analysis is the work of Charmaz (2006) who aligned herself primarily with the Strauss and Corbin tradition of grounded theory however attempting to elucidate the method still further and to account for a more flexible approach to the utilisation of the method.

Charmaz also identified herself with a constructivist ontology and argued that this was a logical development of the pragmatic and interactionism approaches adopted by Corbin and Strauss (2008). In attempting to delineate these three ontologies, Schwandt (1994) concluded that this was a “somewhat artificial disentanglement” (pp130) as the ontologies build one upon the other.

#### ***4.2.2 Constructivism, Symbolic interactionism, pragmatism as the underpinnings of grounded theory methodology***

Charmaz (2006) argued that she had logically developed the ontological premises of grounded theory by moving it into a constructivist realm. Further, Charmaz proposed that the constructivist ontology allows for the consideration of the interaction between the individual and the social situation but furthermore incorporated consideration of the shared experiences of the participants, the relationships between the researcher and the data and also the relationship to other sources of data (Charmaz, 2006). Both Schwandt (1994) and Charmaz (2006) argued that this constructivist ontology lies within the symbolic interactionism tradition.

Authors have argued that original grounded theory methodology is underpinned by the social theory of symbolic interactionism (Blumer, 1986; Morse 2009). Symbolic Interactionism in simplistic terms aims to explore how people interact, and how they seek to understand the meanings that these interactions have for them. On a more complex level, these meanings are further derived from, and arise out of social interactions, which can then be

modified through an interpretive process used by the person in dealing with the things with which they encounter.

Chenitz and Swanson (1986) were amongst the early nurse researchers who stated that grounded theory worked well with symbolic interaction theory. McCann and Clark (2003) argued that grounded theory was founded in symbolic interactionism because the researcher attempts to uncover and make sense of the individual or groups' understanding of a social situation (McCann & Clark, 2003). Holloway and Todres (2003) suggested that the key relationship between grounded theory and symbolic interactionism was that in grounded theory the dynamic nature of the person's interaction with a situation was what the method sought to understand.

Therefore grounded theory analysis identified with the symbolic interaction theory by proposing that participants find meaning in situations through their active participation in the process rather than being passive recipients in a situation:

*“ This means that the researcher follows the tenets of symbolic interactionism – in particular that human beings are not passive recipients of cues or influences of the social environment to which they merely respond; they must be seen as dynamic agents who take an active part in the process, based on the way in which they interpret the situation. In interaction with others they create meaning. This interpretation of social reality and the meaning they attach to action and experience give consistency to the research.”*

As the discourse on grounded theory progressed both Charmaz (2003; 2006) and Morse (2009) argued that grounded theory was not explicitly founded in symbolic interactionism. However, applying symbolic interactionism to the grounded theory method indicated that different interpretations of reality are available to each individual (Holloway & Todres, 2003). This idea of multiple realities was one that Charmaz (2003; 2006) argued was not present in what she believed were the positivist, origins of grounded theory. She argued that to accept that multiple understandings of reality are possible required a move away from the objective positivistic approach of both Glaser and Strauss's (Glaser & Strauss, 1967) original work and the subsequent work of Strauss and Corbin (1990). Corbin and Strauss's iteration of their methodology in 2008 clearly argued for the symbolic interactionism underpinning and not a positivist one.

In setting the underpinning ontology of their grounded theory approach Corbin and Strauss (2008) and more specifically Corbin provided a commentary on the underpinnings of the grounded theory methodology they adopted, which had deviated and developed from the original Glaser and Strauss (1967) method (Glaser, 1992). Corbin aligned herself not only with symbolic interactionism but also with pragmatism, an earlier theory developed by Dewey and Mead (cited in Corbin & Strauss, 2008). Corbin summarised the premise of the pragmatist philosophy as it impacts her methodology thus,

*“...knowledge arises through (note the verbs) acting and interacting of self-reflective beings.”*

(Corbin and Strauss, 2008 pp2)

Corbin went on to consider how a pragmatic ontology impacted upon the issue of establishing truth within grounded theory and identified that pragmatism acknowledged perspective and the impact of the person defining the truth and the understanding, furthermore that the truth was temporal and existed at the time it was relayed and in the future could be scrutinised or re-examined and be found to be wholly or in-part no longer substantiated. The importance of the reflective nature of the individual, Corbin argued, was unique in its interplay with the grounded theory methodology when compared to other qualitative methods and aligned to her professional world view. Her nursing background also led Corbin to identify that a pragmatic and interactionism approach did not divorce theory from practice and the desire for research outcomes to impact upon the real world and guide practice (Corbin & Strauss, 2008).

In the current study symbolic interactionism and pragmatism, as adopted by Corbin and Strauss (2008), were applied as the ontology for the approach. This was because the reflective ability of the individual (whether as researcher, and/or as participant service users) would construct more than one interpretation of a situation. In the researchers view, a key aspect of the

data collected may have greater significance than the service user originally intended. An example of multiple interpretations is illustrated when a service user participant in this study, considered the questions asked during her visit to the LMHS and the manner in which they were asked. The service user, Gill, described finding the manner in which an initial 'screening' question was undertaken as 'unsympathetic' at the time she experienced it. However on reflection, and as part of the recalling process during the research interview, she then felt the nurse in fact did a good job of getting the important information from her and from her partner who was also present. This service user's initial interpretation was very different from the meaning attached when reflecting on the experience, hence demonstrating that the understanding of a situation was unique and influenced by self-reflection. There was no single truth regarding the experience of the questions being asked of her. Capturing this complexity is identified most clearly in later theoretical texts about the constant comparative method, which clearly allow for both interpretations to be considered and where no single understanding of the interaction should be expected or give precedence (Corbin & Strauss, 2008).

In the later aspect of the study, the discussion and theorising of the findings, there is also an element of the constructivist approach outlined by Charmaz (2006) in so much as in order to theorise from the findings consideration was given to the broader context of the data utilising findings from other data sources through published research and furthermore the findings were

considered in the wider political and social climate as the study came to a close.

### **4.3 Approach to data collection**

Silverman (2000) contended that participant interviews were an appropriate method for understanding a person's social experience, particularly when compared to other methods for data collection, such as observation, documentary analysis or recording of naturally occurring interactions through field work. It was proposed that using an observation method of naturally occurring interactions would not have answered the research question posed for this study, as effectively as giving the service user participants opportunity to reflect on the experience of LMHS, through a semi-structured interview (Silverman, 2000). Thus the focus of the study was 'what they [the participants] thought about what they did' (Silverman, 2000), within the context of their experience of the LMHS.

#### **4.3.1 *Semi structured interviews***

Semi structured interviews have been utilized widely in social research, where capturing the participants recollection, story or narratives interviews have been used with the intention of profiling and raising the passive voice of some of society's less powerful groups (Oakley, 2000). For example, feminist interviewing technique deliberately seeks to redress any imbalance of power in the interview setting, where convention had led to the interviewer taking full ownership of what was said and how material was then



represented (Wilkinson & Kitinger, 1996; Holloway & Jefferson, 2000). For the purpose of this research, the intention has been to allow the participant service users to explore and expose their personal experiences. Instead of being too prescriptive in what the respondent could say, through for example a survey, or structured interview; using a semi structured format enabled the researcher to guide the interview process, but also provided the flexibility to probe or diversity, depending on how the respondent was using the prompt questions (the interview guide is available in appendix 3). With little data available regarding satisfaction of service users with LMHC at the time of the primary data analysis semi structured interviews were adopted because they are a recommended option in exploratory studies, where there is a need to prompt and probe the topics of enquiry rather than limiting the participants' responses (Heaton, 2004).

#### **4.4 Analysis of the data: using constant comparative analysis**

In attempting to understand how service users made sense of the experience of using a liaison mental health service, the process of data analysis aimed to uncover the views, beliefs and understanding of the respondents rather than their 'lived experience'. This is integral to a constant comparative analysis and is one of the primary differences between it and phenomenology analysis (Holloway & Todres 2003). Whilst not claiming to be using a classic grounded theory methodology, the data analysis used parts of the approach for data analysis, including coding, theoretical saturation and constant comparison (Lathlean, 2006).

#### ***4.4.1 Theoretical sampling and constant comparative analysis***

When analysing data the researcher takes a stand of being 'other'; that of an outsider, striving to understand the information from the perspective of those using the LMHS (Chenitz & Swanson, 1986; Wilkinson & Kitzinger, 1996). The utilization of secondary data for this study therefore required analysis following the completion of data collection, which is contrary to a purist approach to using grounded theory. The literature indicated that in order to fully adopt a grounded theory methodology the continued analysis of data during the process of data collection is one of grounded theories key components (Strauss & Corbin, 1990). This approach would have allowed the researcher to explore emerging themes with participants in subsequent interviews and could therefore have elicited different data. In this study because the data were all collected prior to a process of analysis taking place, the researcher has theoretically sampled within the data. This was achieved by looking for other examples of concepts and categories and exploring how the different participants understood the meaning of particular events or circumstances.

One of the arguments for the benefits of constant comparative analysis is that it is not a deductive analysis but also inductive, because themes or categories emerge from the data rather than being imposed upon the data. Constant comparative analysis is a key aspect of inductive theory building (Strauss & Corbin, 1990). In this study constant comparison and theoretical sampling was completed by looking for instances of a particular concept or

category from within the existing data. The option of further data collection was maintained until the researcher had satisfied herself that the categories could be explained in enough detail by sampling within the already existing data. If this were not found to be the case further data collection might have been required.

#### **4.4.2 Secondary data analysis and the fit with a grounded theory approach**

The concept of secondary data analysis has been evident in the grounded theory methodology since its inception and was discussed by Glaser (1967) in relation to re-analysing existing data that had previously been collected for another purpose. Corbin and Strauss (2008) addressed the question of whether a grounded theory study can be completed on already collected data and were clear that this is possible,

*Questions about a concept(s) serve as a guide for what incidents to look for in the next set of data. Therefore, a researcher can sample data that have already been collected or are available for incidents pertaining to a concept. ... It doesn't mean that a study will lack significance or be superficial."*

(Corbin & Strauss, 2008 pp150)

Therefore it was argued that the application of the grounded theory approach of a constant comparative analysis to secondary data analysis was a rigorous approach.

#### **4.5 A summary of the methodology**

This chapter has given an overview of the chosen methodological approaches used to capture and reveal service users experiences of LMHC. Adoption of secondary data analysis as a primary methodology to obtain the data for the study consequently means that a pure or classic approach to grounded theory has not been utilized. It has been outlined that a grounded theory approach of constant comparative analysis has been applied to data analysis. The ultimate intention of the research process was a critical interpretation of grounded theory to reveal and create new insight and meaning from the collective interviews. Therefore utilizing the rigour of constant comparative analysis has enabled this interpretation to be open to external scrutiny, and use of the appendix will provide the audit trail for decision making. Further detail of the process undertaken is now explored in the Methods Chapter.

## **5 METHOD**

### **5.1 Introduction**

This chapter provides an outline of methods used to collect and analyse the data. Ethical considerations and applications are discussed. The sampling technique used are described and potential alternative approaches appropriate for the research focus are considered. The process of data analysis using the constant comparative method is explained. Finally issues of theoretical sensitivity and reflexivity are considered.

### **5.2 Research Question**

The empirical aspect of the study seeks to consider the following research question:

*What are service users' experiences of liaison mental health care?*

### **5.3 Aim and Objectives**

#### **5.3.1 Study Aim:**

To explore and theoretically analyse experiences of people who have used liaison mental health services.

#### **5.3.2 Objectives:**

1. To critically consider the impact and implications of research (1975 – 2013) and policy development (1990 – 2013) in the area of Liaison Mental Health Care.
2. To use constant comparative analysis, an aspect of grounded theory, to analyse and present experiences of liaison mental health care service users.

3. To identify and discuss theoretical understanding of the experiences of mental health liaison service users from a case study site in inner London.
4. To provide policy and practice improvement recommendations for contemporary liaison mental health based on the application of findings from the study.

## **5.4 Ethical approval**

The ethical approval obtained for the primary data collection is explained and the ethical considerations when undertaking secondary data analysis are explored below.

### ***5.4.1 Ethical approval for primary data collection***

The application for ethical approval to conduct semi structure interviews was obtained at the time of the primary data collection. Upon application the ethics committee requested that the service user sample be randomly selected, the rationale being that the findings needed to be generalisable. Such mixing of qualitative and quantitative sampling methods used in research has been criticised in the literature (Miles & Huberman, 1994; Sandelowski, 1995; Coyne, 1997; Silverman, 2000; Higginbottom 2004). In order to meet the requirements of the ethics committee, service users who had experience of both A&E and in-patient general hospital care (n=17) were identified through random sampling. Randomly allocated numbers were used with a list of all attendees at the ED over a period of 1 year. There were

423 attendances between June 2000 and June 2001. A proportion of this number would have been repeat attendances by the same individuals; however audit data was not collected in such a way that the number of people attending as opposed to the number of referrals could be extrapolated.

#### **5.4.2 *Ethical considerations for secondary data analysis***

Requirements for ethical approval are constantly evolving and this is the case with ethical approval of secondary analysis. Obtaining informed consent for secondary data analysis, particularly where the researcher is the same person who conducted the original research and primary data analysis has not been common practice (Heaton, 2004; Bishop 2007). However, it remains a point of discussion as to whether when collecting qualitative data consent should be obtained to include potential for future storage and ongoing analysis of the data. It is very difficult to envisage how informed consent could be obtained prospectively for secondary data analysis when at the time of gaining consent what type of analysis and for what purpose it might be used has not yet been identified.

Where data is used by a new researcher and the analysis is not one that looks at questions related to and developed from the original analysis of the data, this is a pertinent issue. Having considered the literature on consent for secondary analysis (Heaton, 2004; Bishop, 2007; Long-Suthehall et al, 2010) it was concluded that further ethical approval or informed consent was not required from the participants in the primary study. Secondary data analysis

is a continuation of the primary analysis, whilst exploring these data from a different methodological perspective the focus remained on extrapolating more detail Heaton (2004). Should future data collection have been undertaken, the options for obtaining consent from participants for storage and archiving of data collected in facilities such as ESDS Qualidata<sup>7</sup> and UK Data Service<sup>8</sup> would have been considered (Bishop, 2007; Long-Sutehall et al 2010). Bishop (2007) advocated the consideration of potential harm to the interview participants in the further analysis of data. It was argued that because the approach taken in this study was to build upon the initial analysis utilising a different but related question which these data inherently appear to answer that the service users would have anticipated that the information given would be utilized to the full in improving understanding LMHC. The analysis of the data was to address a question which remains in the context of the original interviews and the analysis was being conducted by the original researcher, therefore it was anticipated that no harm would come to the original participants as a consequence of the secondary analysis.

## **5.5 Sample**

This section explains the sampling technique used to collect the primary data, alternative approaches to sampling that might have been more akin to qualitative research and then identifies the sampling for the secondary data analysis used in this study.

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<sup>7</sup> <http://www.esds.ac.uk/qualidata/>

<sup>8</sup> <http://ukdataservice.ac.uk/>



### **5.5.1 Sample for primary data collection**

Seventeen semi-structured interviews were completed with liaison mental health service users over a period of ten months between September 2000 and June 2001. The dearth of literature on service users' experiences of LMHC led to the decision to obtain a diverse group of service users, the initial service user sample intended to provide maximum variation (Sandelowski, 1995) via the use of random sampling. The initial aim was to obtain a sample of twenty service users, however only seventeen were recruited within the time constraints of the funded study.

Using the ethical requirement for a random sample the following process was used to identify potential service user interviewees. The LMHS retained a log book of all referrals received. This was maintained in date and time order. The process of interviewing began in August 2000, the referrals in the log book from 1<sup>st</sup> April 2000 to 4<sup>th</sup> August were numbered in date order, and there were 180 referrals during that period. Using a random number table an independent person selected random numbers (Polit & Hungler, 1999). Any random number above 180 was omitted. Initially 30 random numbers were identified to begin the process of follow up and invitation to interview. From this initial random sample of 30 two service users were of no fixed abode so there was no means of follow-up, two service users were repeat attendances and one service user was subsequently found to have died, thus 25 service users were contacted by letter to invite them for interview. The initial letter of invitation is given as Appendix 4. A second letter of follow-up was sent

offering a specific interview date and time if no reply was received from the first letter (Appendix 5), an information leaflet was also included with the letters (Appendix 6). Where possible the 25 potential interviewees were also contacted by telephone to follow-up on the letters. All follow up ceased if the person declined to be interviewed.

Of these 25 initially randomly sampled and contacted by letter and telephone six interviews were obtained. After the initial random sampling of the log from April 2000 to August 2000 the researcher was able to sample randomly from the log on a monthly basis using the process described above. Overall a total of 100 service users were randomly sampled, of these five were of no fixed abode, two were repeat attendances, one had left without treatment and another person had died. Four other service users who had made contact via means other than the random sampling were sent a letter inviting them to be interviewed, three of these had expressed an interest in being interviewed when the researcher was undertaking non-participant observation within the service and one had expressed an interest in being interviewed when they received a postal questionnaire about their satisfaction with the service. In summary 95 service users were contacted by letter and invited to interview, of those 95 seventeen attended an interview with the researcher. All service users who responded to the initial letter agreed to be interviewed. The attempt to continue obtaining service user interviews ceased because the primary data collection of service user interviews was time limited, the time allocated to the researcher to collect the service user interviews ended in June 2001.

### **5.5.2 *Alternative approaches to sampling***

When identifying the sample for the primary data collection, the ethics committee dismissed an initial proposal to utilise a purposive sampling method and required random sampling, a process most frequently used in quantitative methodology and used in order to obtain generalizability. The small sample sizes of qualitative methodology do not attempt to create generalizability as expected in a quantitative study (Silverman, 2000). There is for some qualitative methodologies and data analysis approaches a concern about representativeness (Silverman, 2000), however a constant comparative analysis of data does not seek a sample that is representative but one that provides information to expand the emergent theory of the data analysis (Coyne, 1997; Silverman, 2000 Strauss & Corbin, 1998). Another differentiation between grounded theory and methods such as phenomenology is the articulation of sample sizes, with constant comparative analysis the sample size is dependent on reaching data saturation where not further new themes emerge and all identified themes are rich in information regarding their properties and dimensions (Creswell, 1998; Corbin & Strauss, 2008). Other research methodologies may identify a sample size at the beginning of the data collection (Creswell, 1998).

Regarding “purposeful sampling” (Miles and Huberman, 1994), by which they appear to mean logical sampling (as opposed to purposive sampling which is a specific sampling approach), identify sixteen approaches, including maximum variation, snowballing and convenience sampling. The primary

data collection utilised a thematic content analysis (Berg, 1998) and as such would have benefitted from an approach such as maximum variation where sampling occurred which attempted to replicate the varying demographics and/ or types of presentation to the LMHS, the types of service users to be sampled could have been identified using the knowledge and skills of the clinical team and the information obtained through the audit data collection (Coyne, 1997; Silverman, 2000). Had the current research question been addressed through primary data collection the grounded theory approach of theoretical sampling would have been utilised (Strauss & Corbin, 1990; Corbin & Strauss, 2008).

### ***5.5.3 Sample for secondary data analysis***

It was not necessary to sample within the original data set (Bishop, 2007) because all of the primary data set of seventeen service user interviews contained information regarding the service users' experiences of LMHC. Therefore the secondary data analysis contained seventeen interviews. Of those seventeen interviews, seven service users had used the service only once, six had experiences of between two and three visits and a further four service users identified multiple experiences to draw upon but did not identify the exact number of times they had used the LMHS, therefore of the seventeen interviews there were in excess of 24 separate experiences of LMHC to consider within the data analysis. The average time elapsed between the service user being seen by the LMHS and the interview was 12 weeks. The time lapse varied from 3 weeks to 25 weeks.

## **5.6 Strategies for primary data collection**

Primary data were collected using semi-structured interviews with LMH service users. The prompt sheet for the semi structure interviews is outlined in appendix 3.

### **5.6.1 *Design of the primary data collection semi structure interview guide***

The interview questions were specifically designed to elicit information regarding participants' experience, and evaluation of LMHS (appendix 3). Questions were originally devised by the principal investigator with assistance from the research team drawing on their experience of interview guideline development and clinical knowledge of LMHC. The interview guide began with a broad opening question which aimed to obtain the detail of the service user's overall experience: *"Please describe your experiences of using the liaison mental health service."* Followed by more specific questions which attempted to draw out the detail of the experience, for example *"How accessible do you find this service?"* and evaluation of the service, for example, *"How do you think this service could be improved?"*

The broad initial question highlights the fit of the primary data collection tool with the current secondary data analysis and the research question it aims to answer: To explore and theoretically analyse experiences of people who have used liaison mental health services.

A structured interview would not have enabled the researcher to draw out the details of the experiences of LMHC in depth. An unstructured interview was not considered because the primary data sought to address specific questions of the satisfaction with the service and the strengths and weaknesses, therefore the interview guide needed to ensure that the researcher inquired of the service users regarding these areas.

#### ***5.6.2 Piloting of the semi structure interview guide***

The service user interview guide was piloted with a service user in consultation with their informal carer who were both members of the research steering group and with a service user who was involved in a local support group for mental health service users. They all considered the questions appropriate to address the satisfaction of service users with the LMHS. Analysis of the two pilot interviews by the author and the principle investigator of the original research study using a thematic content analysis (Berg, 1998) confirmed that the interview guide was sufficiently sensitive to answer the primary research question regarding the satisfaction of service users with the LMHS. Pilot interviews were not included within the final data set.

As interviewing progressed it was noted in reviewing and reflecting upon the interviews that service users talked about their expectations. This coupled with the on-going review of the literature which had also identified suggestion

that service users were unlikely to mention the term satisfaction independently but did speak of expectations (Staniszewska & Ahmed 1999) led to a decision to add a question regarding expectations. The question added was “*What were your expectations of the liaison mental health service?*.”

In conducting the interviews service users often addressed the secondary questions as they answered the initial broad question and retold their experiences of using the LMHS, however the secondary questions were revisited by the researcher and at times led to further information being provided. Furthermore in answering the final Likert scale satisfaction question service users often went on to provide more information by expanding with a rationale for their response.

### **5.6.3 Conducting the interviews**

A letter confirming an interview was sent to all those who agreed to participate along with a copy of the study information leaflet (appendix 7) and the consent form (appendix 8). Where the service user was known to mental health services the ethics committee required that the consultant psychiatrist responsible for their care consented to their engagement in the study. Information on those known to mental health services was obtained from the LMHS electronic database. Interviews took place in a variety of settings, within the general hospital (n=2) and mental health inpatient settings (n=2), these took place within private rooms except on one occasion where the interviewee requested to be interviewed at the bedside. One of the mental

health in-patients was provided with support by a health care assistant, the other mental health in-patient declined support for the interview. Eight of the interviews took place at the university offices and five took place at the service user's home. Of the five that took place at the service users home the researcher was accompanied by another researcher, and on two occasions the service user was with a family member or carer. For three of the service users their first language was not English, two declined a translator and a translator accompanied the researcher to the third interview and proved very useful.

At the start of the interview the study was introduced and the consent form was considered, with an explanation offered and any questions answered. The interview would not have proceeded if the service users was not happy to sign the consent form, however all participants signed the consent form.

Interviews ranged in length from 17 minutes to 55 minutes. The majority were between 30 and 40 minutes duration. Fifteen of the interviews were tape recorded, transcribed verbatim by an independent transcriber and subsequently checked for accuracy by the interviewer. Two service users declined to be tape recorded, therefore detailed notes were made during the interview. After the interview the notes were read back to the participant in order for them to make further comment on the accuracy of the notes. As a result some changes to the notes were made to reflect the participant's comments. One of the non-tape recorded interviews included the translator who also read the final transcript of the interview to check for accuracy.



#### **5.6.4 Reflections on the interview process**

The greatest challenge to the interview process was obtaining participants, over the 10 months data collection period. A total of 100 service users were identified and contact was attempted via letter and where available telephone. When data collection ceased seventeen of the twenty interviews had been completed. The challenges of obtaining interviewees is recognised within the qualitative literature (Abrams, 2010), however it could be considered that those who attend LMHS are a challenging group to engage in the research process. Obtaining feedback for the purposes of audit is also acknowledged as challenging with these service users. Services entering into the national accreditation for LMHS (Palmer et al, 2010) struggle to obtain service user feedback and to find service users who will attend peer-review visits as part of the process (Palmer, 2013).

It is not possible to understand the reasons why service users declined to be interviewed, or for that matter why they are reluctant as a group to engage in routine feedback on service provision. However issues that arise from the author's perspective include the brief nature of the interaction with the LMHS in comparison to the overall crisis or illness. An interaction with the LMHS may be one individual intervention amongst many, including an admission to psychiatric hospital or the need for on-going treatment for a physical health issue. Also as will be seen in the findings service users hope not to have to use the service again and therefore perhaps reviewing the experience is also something they wish to avoid. In order to attempt to address the issue of

obtaining greater numbers of participants the research steering group agreed to a nominal incentive of a £5 shopping voucher on participation in the interview, however this did not appear to increase response rates.

Safety during interviews required attention, risk assessment of service users was not possible and a universal cautionary approach was taken when visiting service users at home. Therefore, a second person accompanied the author to offer some level of support should any difficulties arise (such as the person becoming distressed or exhibiting social disturbance). Office based interviews were undertaken alone, however the researcher checked in and out with a colleague at the beginning and end of the interviews, again as a precautionary safety measure.

A number of issues and challenges arose in the conduct of the interviews regarding the use of a translator and the depth of probing undertaken by the author in asking the questions. Three of the interviewees had English as a second language and funds were available for translators. For the first two interviewees a translator was declined by the participants, the data obtained from the interviews was sparse and it occurred to the researcher that the conversational engagement achieved with other interviewees was not present and the researcher was left wondering if the interviews would have developed in more depth if an experienced translator had been available. The two interviewees were both young men who appeared to be to some extent unwell at the time of the interviews so this may have impacted upon their ability to engage in the interview process. Since a translator was

declined the researcher could not offer to return with a translator at a later date.

Non-tape recorded interviews highlighted for the researcher the value in obtaining wherever possible an audio record of the interview. To conduct the interview, attend to the information offered and at the same time to take detailed notes presented challenges to the researcher as have been outlined within the literature (Rubin & Rubin, 1995). It is not possible, in the researcher's opinion to replicate the level of detail obtained from a direct transcript through note taking, nor is it possible to offer the same level of verbal and non-verbal attendance to the interviewee when note taking. This lack of non- verbal re-enforcers and attendance to content reduces the opportunity to encourage as greater depth of information giving as was possible when detailed notes were not required. This is potentially a skill which can develop over time however the reliance on memory rather than verbatim transcription felt less reliable for the researcher.

A number of issues were encountered, namely, engaging prospective participants in the interviews leading to sampling of 100 people to obtain 17 interviews, the challenges of interviewees declining translation support and the issues inherent in note taking during interviews.

## **5.7 Secondary data analysis using a constant comparative method**

The data in this study were analysed using a grounded theory constant comparative method from within data already available. The grounded theory

approaches of Chenitz & Swanson (1986), Strauss & Corbin(1990) and Corbin & Strauss(2008) were applied for the purpose of data analysis. The process of data analysis using constant comparative analysis began with open coding, followed by axial coding, collapsing of categories and finally the determination of a core category. Detail of each of these stages is outlined below.

Having collected all of the data prior to completing the analysis one aspect of the inductive theory building is lost, however the validity of using constant comparative analysis from within data have been discussed in the methodology chapter (chapter 4). The option of further data collection was maintained until the researcher was satisfied that categories could be explained in enough detail by sampling within the already existing data.

#### **5.7.1 *Open coding***

When using constant comparative analysis, open coding is the first level of data analysis. The researcher began the process of analysis by exploring line by line and sentence by sentence the service user's understanding of their experience with the LMHS. Each concept was identified and then coded. Where other examples or phenomena or a concept were identified they are grouped together to form a category. Each interview was summarized in a separate document to assist the researcher in summarising the key aspects of the LMHS experience for each service user. This assisted the researcher in becoming familiar with each service user's experience.

Naming categories was considered by Strauss and Corbin (1990) who identified that some categories may be named/labelled using the researcher's knowledge of the professional literature or from their professional experience. This acknowledges the reality that one cannot entirely remove oneself from the existence of prior knowledge. An example of such a category in the current study would be "therapeutic benefit of assessment" in so much as 'therapeutic' is a recognised professional term, identifying an effective assessment and also one which has engaged the service user effectively (O'Carroll & Park, 2007; Hewitt et al, 2009). Another approach to naming categories was that of using the words of the service user, this is called "in vivo coding". To illustrate an 'in vivo' category, taken directly from an interview with service user Brynn, would be "sympathetic hearing". Alternatively the name for a category may simply offer a logical reminder to the researcher of the content and provide a summarised aide memoire for the researcher about the content of the information contained therein; an example of this was the category "potential harm", contained within this category were many examples of the harm that might have occurred or did occur prior to and following experience of the LMHS.

Having considered a single interview transcript the process was repeated with the next transcript. However, from this point onwards the constant comparison began. The researcher sought to identify if previously identified codes and categories were repeated within the next transcript and considered how the information pertaining to the codes and categories was similar or different and whether it shed further light on the understanding of

the phenomena that had been identified. Identifying further instances of a code or category assisted the researcher in understanding the properties and dimensions of a category (Bradley et al, 2007). The properties and dimensions of each category (Strauss & Corbin, 1990; Corbin & Strauss, 2008) are described as the characteristics of a category (properties) and the continuum of those experiences (dimensions). The application of properties and dimensions to each category continued when categories were further collapsed in higher level coding such as axial coding. Returning to the example code “potential harm” this category contained examples of harm to the individual directly such as self-harm or suicidal attempts, harm to the person’s relationships and also employment status, these represented the properties. For the property “harm to self” the category contained examples of actual harm, the potential for actual harm including suicidal intent and more abstract comments that eluded to not knowing what the service user might have done if they had not obtained help, representing a continuum of experiences and potential experiences (the dimensions).

As each interview transcript was consumed into the coding, new codes arose that did not fit within already identified categories. When one was identified the researcher returned to the previously considered transcripts to sample within the data to establish if the code existed but was not apparent to the researcher. This was also part of the constant comparative method (Strauss and Corbin, 1990). The process of constant comparison with analysis of new interviews and the reanalysis of old ones was repeated until a point was reached where no new codes or categories were developed from the open

coding process. The final two transcripts considered yielded no new codes when the transcripts were analysed for this study, therefore data saturation was seen to have been reached.

During the process of open coding the researcher sought advice and practical support from two colleagues. First, the principal supervisor at the time, Dr Barbara Johnson (BJ), and the researcher completed line by line and identification of initial codes and categories on the first transcript together, this served to offer the researcher an understanding of the process. Secondly, a colleague familiar with the grounded theory methodology and LMHC agreed to consider a further transcript. The insights and codes she identified were discussed and helped the researcher to check that their interpretation of the transcripts met with another researcher's interpretation.

Once this constant comparison and open coding was achieved the analysis moved on to the next level which Strauss & Corbin (1990) described as axial coding.

### **5.7.2 Axial coding**

The researcher then sought to build an understanding of each category which included a number of different aspects. However these aspects (of each category) were described differently by individual writers in the field of grounded theory. For example, Glaser (1978) described these aspects as the six C's: *cause, context, contingencies, consequences, covariance and conditions*.

Strauss and Corbin (1990) on the other hand refer to aspects as the context, action/ interaction strategies and consequences. Despite this deviation, in both iterations some categories become aspects of other categories, and through this process a higher order of categories and subcategories are created. Strauss and Corbin (1990) recommend what they term the paradigm model as a means of assisting in understanding how sub-categories relate to the higher order axial code, derived from the collapsing of categories, which is the essence of axial coding. They argue that the application of the model helps to ensure the density and precision of the analysis (Strauss & Corbin, 1990). The paradigm model remains a key aspect of the later revision of the guidance on conducting constant comparative analysis (Corbin & Strauss, 2008).

An example of the application of the paradigm model with the identification of the phenomenon, which is the central idea; the causal conditions, context, intervening conditions, action and interaction strategies and the consequences is given in section 6.4 of chapter 6 – findings, and is diagrammatically represented in figure 6.2 also in chapter 6. Overall three axial codes were identified in the current study, which are explored at length in the findings chapter and the relationships between each axial code and the sub categories are explained. The logic of the three axial codes is in representing the process of the experience of LMHC. Charmaz (2006) identified that in theorizing about data the focus should be upon actions and processes. In identifying these higher level axial codes, the assistance of the



current primary supervisor, Professor Sally Hardy (SH), was enlisted. She provided a scrutinizing presence for the researcher; constantly challenging the decisions and the connections that were made between lower level categories and a higher level axial code. At a very basic level this involved a considerable number of post it notes and an intensive day of arrangement and rearrangement of the categories to obtain a precise model of the service users' experiences of LMHC. Having no clinical experience of the LMHC field, Professor Hardy was able to lend a critical eye to the decision making; therefore the placement of each category was explained, challenged and justified until a coherent whole was created. A diagram showing the axial coding and its relationship to the categories and codes is provided in chapter 6 (figure 6.3).

The model for stages in the process of data analysis presented above appears very linear and this is a helpful way to begin to understand the process. However the process of data analysis does not remain linear. It became clear early on in the analysis process that some of the categories created could become sub categories of others, or at least linked in some way.

Appendix 9 offers an example of an annotated coding memo for the category "*opportunity to talk*" that illustrates this non-linear process. The memo shows the collapsing of two initial codes "*opportunity to talk*" and "*time to talk*", this occurs because the codes are similar in content, i.e. much of the same data was coded to them, however this was revisited and through the constant

comparison process data emerges that perhaps challenges this merger, however this does not lead to any further sustainment to the idea of separating the categories out again. In maintaining the focus of the analysis upon the research question, that of *“what are the experiences of service users who use the LMHS?”* A summary is undertaken which reviews the properties such as seeking out the known service to talk, continuing an incomplete dialogue and wishing to tell their story. The summary also draws out some of the dimensions of the category, the brevity versus length and the issue of clock watching. The memo also shows the linking of the category to other categories such as the potential for further harm and the therapeutic assessment.

The above observation from the research experience, that constant comparative analysis does not occur as a linear process, was mirrored in the change which occurs over time in how the Strauss and Corbin method of constant comparative analysis was described in the literature. In the 1990 edition of the *Basics of Qualitative Research* (Strauss & Corbin, 1990) the process of open and axial coding were presented in a linear fashion and as a novice to grounded theory method this at first appeared very attractive to the researcher. However in the 2008 version of the text Corbin acknowledged that much of this work goes on in tandem and cannot be separated out in a linear fashion;

*“In previous editions of this book there was mention of something called axial coding. ... open coding and axial coding go hand in hand.*

*The distinctions made between the two types of coding are “artificial” and for explanatory purposes only. ... As analysts work with data their minds automatically make connections...”*

(Corbin & Strauss, 2008 pp198)

### **5.7.3 Core category**

Further analysis sought to find a relationship between categories and higher level axial codes which then led to their integration into a core category. Strauss and Corbin (1990) described this as the central phenomenon of the study and it should be possible to link this core category to all other categories.

In identifying the core category the researcher found it extremely helpful to use the tool of creating a storyline (Strauss & Corbin, 1990; Corbin & Strauss, 2008). The storyline is a short description of what the analysis tells the researcher in answer to the research question. The story line is provided at the beginning of the findings chapter, section 6.3.1. The core category which emerged from the analysis was first identified as an interesting phenomenon during the first level open coding undertaken with Dr Johnson. However *“negotiating and navigating the system”* was not confirmed as the core category until the process of axial coding was complete and the concept of the journey through LMHC and the processes as the means of integrating the categories came together. The storyline was used to confirm that the categories could be linked to the concept of negotiating and navigating.

#### **5.7.4 Integration of theory**

Once a core category was identified the literature was then further reviewed (McCann & Clark, 2003) to look for comparative themes/categories in studies of service user experience. Within the discussion (Chapter 7) an attempt is made to link findings to other types of patient experience studies because, as the literature review has indicated (Chapter 3), there was little comparative data within the specific area of liaison mental health. Theoretical perspectives were sought in the literature that might shed light upon the categories identified in this study. This approach to reviewing the literature for explanation and comparison after the initial analysis is part of a grounded theory approach to analysis (Strauss & Corbin, 1990) and theorising about the findings (Charmaz, 2006; Corbin & Strauss, 2008).

### **5.8 Maintaining Objectivity towards the data during analysis**

Throughout the process of data analysis it was important to consider the objectivity of the researcher in terms of their stance towards the data. Within the grounded theory literature the terms theoretical sensitivity and reflexivity are used (Strauss & Corbin, 1990; Corbin & Strauss, 2008).

#### **5.8.1 Theoretical sensitivity in data analysis**

Theoretical sensitivity to data can be enhanced in a number of ways. Theoretical sensitivity is the '*ability to "see" with analytic depth what is there within the data*' (Strauss & Corbin, 1990 pp76). The literature review was undertaken in two parts. An initial review enabled a familiarisation with the literature relating to LMHC. This provided a background and sensitization to

the phenomena (Strauss & Corbin, 1990; McCann & Clark, 2003). Professional experience can also help understanding of the data within its context.

However there are a number of pitfalls identified in having this professional experience, as the researcher. First, a 'naïve' researcher is more inquisitive and potentially less prone to jump to conclusions when a participant is talking about their experience (Bonner & Tolhurst, 2002). Whilst undertaking data analysis with my supervisor (BJ) who had no professional experience of LMHC, it was interesting to note that she would have followed up a number of responses that I did not feel the need to, as I had insight into the clinical significance. At the time this seemed to be about the implicit understanding I felt I had of the participant's response. However, having undertaken this process of analysis, when undertaking a research interview I would now be more curious and seek further clarification of what I might have felt I had initially understood. Professional experience of a setting can therefore constrain theoretical sensitivity as well as enhance it.

Another type of theoretical sensitivity is that of personal experience. In this study I did not have personal experience of working in LMHC prior to conducting the interviews and sought to understand the experience of LMHS through the interviews with service users. Since completing the original interviews and during the extensive period of data analysis I have acquired greater knowledge and experience of the field of LMHC, with clinical experience spanning seven years, eleven years of engagement with a

professional forum for LMH nurses, experience of running a degree level module in LMHC for seven years and latterly national representation of the Royal College of Nursing on a LMHS accreditation panel (Palmer et al, 2010) and in drafting updated national guidelines on LMHC (RCPsych, 2013).

I am considered a knowledgeable practitioner and recognised academic within the field of LMHS, this experience has continued to be developed over the course of the study. This practical insider knowledge and experience has enabled me to see and read the data in the context of professional LMHC; however these ideas were not preconceived, as my experience continued to be developed as the analysis progressed, rather than prior to it. The analysis that I have undertaken has been supported by supervisors who do not have experience of LMHC but, like me, have also been practising nurses (BJ & SH) used as another practical influence upon approaching the data and remaining sensitive to applicability to service delivery and the service user experience, thus increasing the credibility of findings to the practice context.

### **5.8.2 Maintaining theoretical sensitivity**

In response to the potential pitfalls of having prior experience and knowledge in the area under study, Strauss and Corbin (1990) suggest three techniques to ensure that balance in applying experience and bracketing experience is maintained. Firstly, to step back from the data whilst analysing and consider the question: “*Does what I think I see fit the reality of the data?*” (Strauss & Corbin, 1990 pp44). Secondly, all concepts and hypotheses should remain

provisional and the researcher sceptical about them until they are strongly supported by and from the actual data, hence the importance of constant comparative analysis. Thirdly, the importance of following the systematic research process when analysing the data was emphasised. As a result, I have myself found that constantly considering if I was really representing the perspective of the service user has been very useful. This required me to constantly check and critically reflect whether or not I have added and preferenced a professional interpretation and have therefore lost or foreshadowed the user voice in coding the data. This approach fits with Strauss and Corbin's (1990) second step of remaining sceptical throughout data analysis. This process required the researcher to regularly return to the original data to re-engage with the service user voice, as coding and collapsing of the categories continues.

### **5.8.3 Reflexivity**

Reflexivity is the term used to describe the ability of the researcher to present for the reader their position and personal effect upon the research process. This includes “*examining the impact of the position, perspective and presence of the researcher...*” (Finlay, 2002 pp532). The researcher needed to consider this in all aspects of the research process including the process of interviewing participants.

Corbin and Strauss (2008) stressed the importance of remaining ‘sensitive’ to the impact of ‘self’ as researchers, because they stated it is impossible to obtain objectivity. The particular perspectives of the researcher can help in

interpreting and understand better the data. Glaser (1992) described this as the research talking through the “eyes” of the researcher. Data analysis is subject to personal influences and therefore, a researcher becomes responsible for becoming aware of these influences through taking a reflexive stance in research. In grounded theory objectivity, (i.e. a lack of any previous knowledge, experience or theory or data immersion) would be a disadvantage;

*“...we have to have some background, either through immersion in the data or through personal experience, in order to know what we are “seeing” in data is significant and to be able to discern important connections between concepts.”*

(Corbin & Strauss, 2008 pp 34)

To help maintain sensitivity Corbin and Strauss (2008) offer the following three pieces of advice; (i) don't assume knowledge or experience is correct always compare how it fits with the data collected. (ii) stay with the grounded theory method whereby the researcher constantly looks for similarities and differences (properties and dimensions) in the data collected (iii) what the participants say and do is more important than the researcher's own perception of an event. Writing out the first level coding, which was a summary of the data or experience from the participant's perspective, was one way of maintaining this focus. Cutcliffe (2003) considered the issue of reflexivity in some depth and from the perspective of a mental health nursing background, he drew upon a variety of theories to challenge the desire of qualitative researcher to be able to account at all times for their personal



impact upon the data drawing upon concepts such as the “Johari window” and “tacit knowledge” to argue that we can only have a small insight into our influence upon data and therefore that ideas such as bracketing (Ahern, 1999) can only deal with our known influence and not our unknown influence. However he acknowledged that self-awareness of impact may well grow with the research process; the author became more concerned as the write up began, to ensure that the user voice was strongly present and maintained a critical eye upon any description and re-presentation, aiming, if anything, to increase the user voice within the narrative.

Cutcliffe (2003) also considered not only the impact of the researcher upon the data, but also the impact of the data upon the researcher. Having heard the experience of service users before engaging in clinical and education practice in the field of LMH there is no doubt that there is an impact upon the researcher and her practice. An example from the simple use of the term ‘in a minute’ by a service user and its impact upon practice and education will be considered within the discussion (Chapter 7, section 7.4.3.3: Realistic management of expectations helps service users).

#### ***5.8.4 Summarising the researcher’s impact upon data analysis***

In summary, adopting a grounded theory perspective whether the researcher is an outsider or an insider (Bonner & Tolhurst, 2002) to the context being investigated, does not affect the researcher’s ability to undertake the research. What is of importance is that the researcher is clear about their

stance but also that they are aware of that stance and do not impose that stance on the data to the point that they cannot 'hear' what the data is saying. The researcher's prior or current involvement in the field of data collection should not stop them from gaining new insights into the area of study. Researchers should not mould the data to fit their own understanding of the phenomena the data should speak for itself. The researcher's analysis of the data is inevitably affected by her experiences as a mental health nurse and within LMHC, it is conceivable that a researcher with a different perspective, for example a service user researcher (Beresford, 2003) would present a different interpretation of these data influenced by their own experiences, this issue is considered further in the recommendations (chapter 8).

## **5.9 Summary statement of the method & introducing the study findings**

The chapter has considered the method applied to the primary data collection, including the sampling strategy and the receipt of ethical approval for data collection. Consideration was given to more appropriate data collection methods such as purposive and theoretical sampling. In the context of the secondary data analysis ethical considerations, particularly the lack of informed consent, has been considered. The approach to secondary data analysis, namely the grounded theory method of constant comparative analysis, drawing upon the method suggested by Strauss and Corbin (1990), has been described. This has included the approaches of open and axial

coding and the selective coding process of identifying a core category. The chapter has also considered the issues of reflexivity and theoretical sensitivity which present the researcher with some tensions because experiences and knowledge which can be seen to lend insights into the meaning and interpretation of data can also impair the researcher's ability to be entirely open to new insights that arise from within the data and may cloud the voice of the service user. Therefore the researcher must be clear about their personal impact upon the data, in so far as they can be, and a reflective awareness of the impact of the researcher's stance upon the data was required. Having outlined the method of data analysis the next chapter presents the findings, beginning by way of an overview of the service user experience with the story line which helps the researcher to determine the fit of the core category.

## **6 FINDINGS**

In exploring the findings within this chapter, the aim is to present the service user perspectives as closely as possible to their experiences as recalled in the story's they told during the interviews. The service user interviews revealed complex, sophisticated interactions that intertwine to produce interesting details of their experiences of LMHC. As the chapter moves towards the core category the service user experiences are unwound and then re-presented as an analytic version of the collective service users' stories. This chapter presents study findings around the interactions and inter-relationships between the service user experiences and the liaison mental health service they encountered.

### **6.1 Introduction to study findings**

The findings chapter presents the analysis of the interview data. First, experiences of service users when accessing liaison mental health services within an inner city hospital case study site in England are described. The chapter begins with presentation of demographic information about the seventeen service users interviewed between September 2000 and June 2001. Information relating to the total number of service users seen by the liaison service in the year that the interviewed service users attended is also included in Table 6.1. The service users interviewed had broadly similar characteristics to the overall attendees.

A summary of the experience from the service user perspective is provided. Developing a brief storyline to summarise the experience is a technique recommended by Strauss and Corbin (1990), it provides an overview of the journey and sets out the key aspects of the experience that emerge from the data. What follows the overview summary is an in depth articulation of the three axial codes that emerged from the constant comparative method of data analysis. These codes are: firstly, the experience of pre-contact and build-up of an unresolved psychological crisis and secondly, entering the emergency department and the liaison mental health service is presented. The third code is called 'outcomes' and includes both positive and negative experiences. In depth analysis of these data enabled identification of what experiences of LMHC could lead to positive outcomes in regard to support for service users with psychological distress who present in the general hospital setting.

Following the in-depth articulation of the three axial codes, the core category is presented. As part of the inductive theory building of a grounded theory approach it is imperative to identify a core category from the data analysis (Strauss & Corbin, 1990). The core category which emerged was **'negotiating and navigating the system'**.

## **6.1 The profile of liaison mental health service users interviewed**

The demographic information relating to the service users who agreed to be interviewed are presented in Table 6.1. Seventeen service users were

interviewed, although these service users had many more than just seventeen experiences of interactions with the LMHS to draw upon in their interviews. They were therefore able to make comparisons and undertake reflections from one experience to another. Seven of the 17 service users interviewed had used the service only once, the other ten service users had made a minimum of two visits, four had made multiple visits to the service. Therefore the findings draw upon the experience of a minimum of 25 identified visits to the LMHS. However of the four service users who had multiple visits they were unable to recall the exact number of times they had accessed the service.

The majority of service users interviewed had been identified as potential participants as a result of a visit to the ED. Whilst only two service users entered the study due to an episode of care on a general hospital ward three further service users had previous or subsequent experiences of being seen on a general hospital ward by the LMHS.

The geographical spread of the service users interviewed was similar to those of the total patients seen during the year of the interviews (these data are anonymised within table 6.1). Service users interviewed were primarily from the area surrounding the case study site. Ten male service users along with seven female service users were interviewed. In the year of the interviews (2000 – 2001) more men than women were seen by the LMHS, from routine audit figures kept by the case study LMHS. Ten of the service

users interviewed had experiences of self-harm that led to an assessment by the LMHS.

Table 6.1 (below) describes the demographics for all interviewees and shows data for the total patients seen by the LMHS in the same year as the interviewees (2000-2001).

<b>DEMOGRAPHIC</b>	<b>1 YEAR AUDIT 2000 -2001 (N=423)</b>	<b>SERVICE USER INTERVIEWS 2000-2001 (N=17)</b>
<b>Referral</b>	<b>(%)</b>	<b>(%)</b>
<b>Ward</b>	89 (21.0)	2 (11.8)
<b>A&amp;E</b>	334 (78.8)	15 (88.2)
<b>Gender</b>		
<b>Male</b>	233 (56.7)	10 (58.8)
<b>Female</b>	178 (43.3)	7 (41.2)
<b>Mean Age</b>	34.5	32
<b>Postcode</b>		
<b>Local Borough 1</b>	74 (17.9)	5 (29.4)
<b>Local Borough 2</b>	90 (21.8)	4 (23.5)
<b>Local Borough 3</b>	72 (17.4)	1 (5.9)
<b>Local Borough 4</b>	63 (15.3)	1 (5.9)
<b>Neighbouring Borough 1</b>	11 (2.7)	0

DEMOGRAPHIC	1 YEAR AUDIT 2000 -2001 (N=423)	SERVICE USER INTERVIEWS 2000-2001 (N=17)
Other London	97 (22.9)	6 (35.2)
Accommodation		
Permanent	207 (75.3)	11 (64.7)
Temporary	54 (19.6)	4 (23.5)
NFA <sup>9</sup>	14 (5.1)	1 (5.9)

**Table 6.1: Demographic Information for Service Users Interviewed**

## **6.2 An overview storyline of service user experience of liaison mental health care**

This section gives an overview of the story line that has emerged from the analysis of the 17 service user interviews. Development of a story line serves as a useful tool to help the researcher summarise the analysis and draw out the core category (Strauss & Corbin, 1990). The story is then developed, in much greater depth through the subsequent sections relating to the axial codes and the core category.

### **6.2.1 What are service users' experiences of liaison mental health care?**

It was evident from the service users' experiences that before accessing LMHS each service user experienced a build-up of a psychological crisis. As their distress intensified the person initially avoided using the LMHS, for

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<sup>9</sup> No Fixed abode.



example by seeking support from family and friends. This might also be because the service user was unaware of what mental health services were available or how to access them. However, when the service users reported previous experiences of asking for help, in the ED or on a hospital ward, they encountered many barriers to accessing LMHS. These were issues such as negative attitudes expressed by dismissive communication received from non-mental health trained professional staff.

Access was not always possible and a service user had a variety of both positive and negative experiences dependant on the time they arrived, the wait, how believed they feel and how clear the action plan was for them. No matter how difficult the experience of navigating the system; the LMHS serves was a potential safety net against harm, although it did not always prevent it.

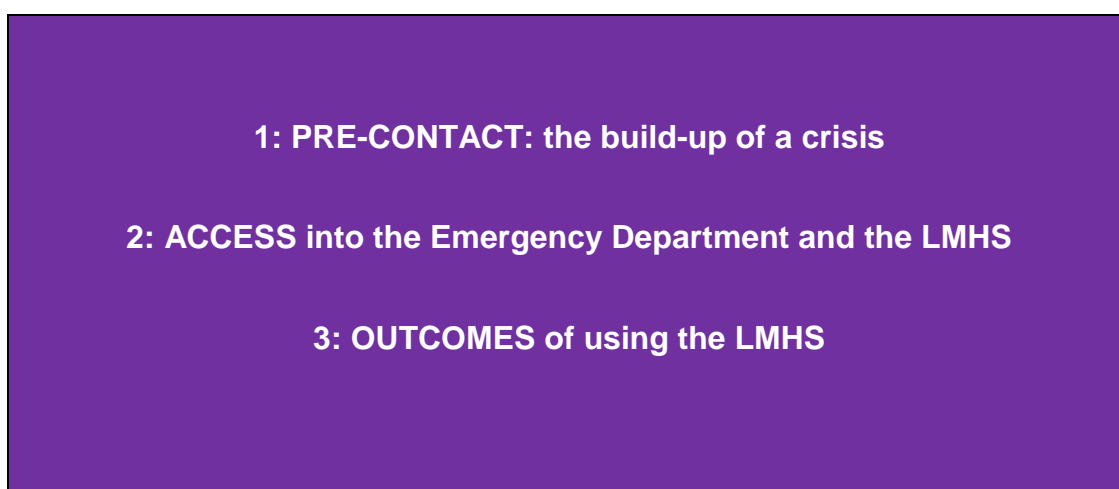
Once access was gained to the LMHS, there might be a long and difficult wait to negotiate before actually being seen by a LMH professional for an initial assessment. What was identified as key to gaining a positive experience was the opportunity to talk about their circumstances and to obtain a feeling of the difficulties presented being taken seriously. The initial encounter experience, when helpful to the service user, needed to offer that person some tangible help. Sometimes help was considered to be through discussing a useful alternative view of their situation or through the identification that there are some clear outcomes attainable. When the

service user navigated into the LMHS and was able to negotiate a positive outcome, the experience moved the person from a place of fear and hopelessness through to feeling believed, then into a sense of hope and a new way of looking at and managing their distress.

### **6.3 Explanation of the axial codes and the relationships of *categories***

The three phenomena that became the axial codes are discussed in turn drawing out the experiences that come together to form each phenomena.

The 3 codes are presented below in figure 6.1



**Figure 6.1: Axial Codes from the analysis of the service user experience of LMHC**

Strauss and Corbin (1990) recommend that in order to ensure depth and density the overall phenomena (in this case experience of using the LMHS) that it is considered in terms of what influences its development, causes or antecedents and how this can be affected by context, intervening conditions

and how people and issues interact with the phenomena. This aspect of the constant comparative method is called the *Paradigm model* (Strauss & Corbin, 1990). In order to demonstrate the worth of the paradigm model to the researcher a diagrammatic representation of how open coding categories come together to form the first phenomena of pre-contact – build-up of a crisis is given below in Figure 6.2.

PHENOMENON: "PRE-CONTACT – BUILD-UP OF A CRISIS"	
CAUSAL CONDITIONS	Hopelessness
	Potential harm
PHENOMENON	Pre-contact – build-up of a crisis
CONTEXT	Hopelessness
	Fear
	Past experience – comparison
	Safety net
INTERVENING CONDITIONS	Not knowing where to go
	Return if you need to - Safety net
ACTION / INTERACTION	Friends before A&E
STRATEGIES	Trying to make sense of what happened
CONSEQUENCES:	Expectations

**Figure 6.2: Axial Coding for the Phenomenon – Pre-contact: build-up of a crisis**

Each axial code is now taken in turn and expanded using the original open coding categories and additional analytic interpretation to explore the experiences of the service users. Memos and coding are used to contextualise the categories and give a voice directly to the service users. In presenting each phenomenon the open codes that come together to form the axial code are identified in the text using **bold** highlighting. A summary of the axial code and the open coding categories that form each axial code is provided in figure 6.3.

<b>Causal conditions</b>	<ul style="list-style-type: none"> <li>• Hopelessness</li> <li>• Potential harm</li> </ul>	<b>Causal conditions</b>	<ul style="list-style-type: none"> <li>• Potential harm</li> <li>• The service should exist</li> <li>• Out of hours presentation – negative experience</li> <li>• Others perceptions of mental state/ perception</li> <li>• First experience of mental health services</li> </ul>	<b>Causal conditions</b>	<ul style="list-style-type: none"> <li>• Trying to make sense of what happened</li> <li>• Potential harm</li> </ul>
<b>Phenomenon</b>	<b>PRE-CONTACT – BUILD-UP OF A CRISIS</b>	<b>Phenomenon</b>	<b>INTO A&amp;E AND LMHS</b>	<b>Phenomenon</b>	<b>OUTCOMES</b>
<b>Context</b>	<ul style="list-style-type: none"> <li>• Hopelessness</li> <li>• Fear</li> <li>• Past experience – comparison</li> </ul>	<b>Context</b>	<ul style="list-style-type: none"> <li>• Not aware of the referral</li> <li>• Can't differentiate who's who</li> <li>• Qualified staff</li> <li>• Specific clinical knowledge</li> <li>• Effect of who's accompanying them</li> </ul>	<b>Context</b>	<ul style="list-style-type: none"> <li>• How the person feels about the assessment</li> <li>• Reluctant to criticise</li> <li>• In a minute</li> <li>• Privacy</li> <li>• Comments about the interview room</li> </ul>
<b>Intervening conditions</b>	<ul style="list-style-type: none"> <li>• Not knowing where else to go</li> <li>• Return if you need to</li> <li>• Safety net</li> </ul>	<b>Intervening conditions</b>	<ul style="list-style-type: none"> <li>• Considerate approach to carers</li> <li>• Info on how carers felt</li> <li>• Negative attitudes of no- mental health staff</li> <li>• Sympathetic hearing</li> <li>• Background and history known</li> <li>• Thorough assessment</li> </ul>	<b>Intervening conditions</b>	<ul style="list-style-type: none"> <li>• Liaison with other services</li> <li>• Local knowledge</li> <li>• Follow-up</li> </ul>
<b>Action/ interaction strategies</b>	<ul style="list-style-type: none"> <li>• Friends before A&amp;E</li> <li>• Trying to make sense of what happened</li> </ul>	<b>Action/ interaction strategies</b>	<ul style="list-style-type: none"> <li>• Opportunity to talk</li> <li>• Time to talk</li> </ul>	<b>Action/ interaction strategies</b>	<ul style="list-style-type: none"> <li>• Diagnosis</li> <li>• Attaching labels to problems</li> <li>• Offering another perspective</li> </ul>
<b>Consequences</b>	<ul style="list-style-type: none"> <li>• Expectations</li> <li>• Safety net</li> <li>• Potential Harm</li> </ul>	<b>Consequences</b>	<ul style="list-style-type: none"> <li>• Potential harm</li> <li>• Feeling believed</li> <li>• Therapeutic benefit of the assessment</li> <li>• Joined up process kept informed</li> <li>• Transparent process</li> <li>• Safety net</li> <li>• Prevention – what could have been if things had gone right</li> </ul>	<b>Consequences</b>	<ul style="list-style-type: none"> <li>• Potential harm</li> <li>• Feeling helped</li> <li>• Return if you need to – safety net</li> <li>• Action plan / outcomes</li> <li>• Offer contacts</li> <li>• Hope</li> </ul>

**Figure 6.3: Axial coding for the data - applying the paradigm model to structure the collapsing of categories**

### **6.3.1 Pre contact – the build-up of a crisis**

This axial code describes the experiences that lead to the service user coming into contact with the LMHS. Each service user interviewed was able to describe a level of psychological distress that had brought them to a point of referral or self-referral into the LMHS. It appears that in order for service users to arrive at a point of gaining contact with LMHS they have already begun a journey and an experience of psychological distress.

#### *6.3.1.1 Pre Contact: recognition and expectations*

In the **build-up of a psychological crisis** there is a phase of pre contact with LMHC where the service user and/ or those around them can identify that there is a problem.

*“I couldn't concentrate on anything, I was doing very excessive and outrageous things, I wasn't eating, I wasn't sleeping and um my friend A said to me look you've got to, this has got to stop somewhere (yeah) and and we didn't know what to do so we agreed we would go around to A&E and see them.”*

(Mark)

There is a sense of **fear** and **hopelessness** in the above narrative that many service users identified. In attempting to resolve this crisis point in their psychological well-being the service user may have sought help informally through speaking to **friends before attending the ED** or making their distress known formally, through for example attending the GP. They may have already presented at the ED or presented psychological distress on the

in-patient ward without being referred to the LMHS or having been referred leave without seeing the LMHS.

*“...because when I was at the Doctor's, what I really noticed this time, being ill, was that the symptoms became physical and that was really frightening, because I started to shake and I started to and over a period of months my stomach had been like a wave machine and I had blurred vision and I think in that situation, I just thought hospital, lots of people there, someone is going to know, someone is going to be able to help me, help!”*

(Olivia)

In this pre-contact build-up stage, service users reported **not knowing where to go** and were aware that there is a risk of actual or **potential harm** to themselves as a consequence of the psychological distress.

*“I mean, as I said for me it was... I didn't know how to make myself feel better...With me, when I feel that depressed, I don't trust myself, that although I know I don't want to like I may get suicidal and I don't want to do that but it is like a frustration that you can't shake off this feeling, and you just get on and cope and do what other people can normally do. You know during a crisis I just don't seem able to do it.”*

(Patience)

For the service users who are able to clearly articulate a potential to harm themselves, of which there are a number, the sense of **hopelessness** is evident in their discourse. This hopelessness is also there for many of the

other service users who do not directly or in-directly speak of the desire to be dead or thoughts of harming themselves.

One service user (Ahmed) referred to the challenges he presented to the LMHS service, because he *'isn't rationale and reasonable'* when totally absorbed in his own problems. At the same time, when he improved he recognised how he also rejects offers of help because he doesn't want or feels he then needs them. Another service user, Brynn, spoke about an increasing confusion about his mental state and about how he was feeling. There was a sense of vulnerability and many references to low self-esteem and a loss of self-worth in his narrative, indicating this intense feeling of hopelessness.

Many spoke of how past experiences or anticipated experiences lead to people feeling scared about what might be wrong with them. One lady, Patience, expressed fears about being admitted to a psychiatric hospital and fears that her postnatal depression may in fact be the beginnings of a life-long mental health issue which she had seen her mother suffer from. Fear and feeling frightened may be a symptom of the mental health problem the service users are experiencing. In addition, the idea of both general and psychiatric hospital admission may present a scary and frightening prospect for service users, based on direct experience or on the perception of what either of these settings might be like, or able to offer. For example Nadia talks about her experience of the general hospital,



*“I was admitted, my nerves got increasing worse to um....a lot of it was to do with treatment on the wards by staff and not knowing what was happening to me (**right**) um, I was in a really a panic stricken state.”*

(Nadia)

Patience talks about her feelings regarding returning to a psychiatric hospital,

*“I didn't want to go into hospital because of my children. I had been in hospital before when my son was born for six weeks, so there was no way that I wanted to sort of leave him again. ... when I am in hospital, if I started crying they would be shoving Lorazepam<sup>10</sup> down my throat just to sort of quieten me down.”*

(Patience)

Both of these service users describe hospital admissions as problematic which, in Patience's case, leads to her not wanting to be admitted, coupled with her responsibilities to care for her children.

Of the 17 service users who were interviewed they offered varied reasons for using the LMHS. These included psychological distress caused by or effecting relationships, feeling suicidal and/or feeling fearful that they might cause some harm to themselves. Some service users were seen following an overdose or other acts of self-harm or suicide attempts. Those who had

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<sup>10</sup> Lorazepam is a medication group called benzodiazepines that works on chemical interactions in the brain that may become unbalanced and cause anxiety. It is used primarily to induce a state of relaxation.

attempted suicide would have been seen by the ED staff as a medical emergency, and often admitted to hospital before being seen by the LMHS. In the case of serious self-harm the decision to offer the service would have been made on their behalf by the ED or ward staff. As well as those who were seen on the wards having been admitted following self-harm other service users had received an intervention whilst admitted for physical health issues or perceived their need for LMHC to be primarily due to the interaction between their physical and mental health issues.

There are various descriptions of mental illness ranging from psychotic episodes as part of a long-term mental health issue through diagnosed depression to the use of generic terms such as mentally ill. For some of the service users who had long term mental health issues the service offered a 'drop-in' facility that helped maintain their stability in the community. This idea of a **safety net** runs through the experience of LMHC and the explanation of this concept continues in the following axial codes and in the discussion of the core category.

In making a decision to attend the ED or ask for help on the ward, service users form expectations. First, that they will be seen by a professional, and that this will be achieved in a timely way. For many the expectations focused on being seen by a medical professional, and that their role included prescribing and reviewing medication. Admission to a psychiatric hospital was also considered the domain of the medical professional. The overall

impression service users gave was that they expected the person assessing to be a doctor, (i.e. a psychiatrist). There is for some a clear aspect of trust, of placing themselves into the hands of someone who will make the right decision. These types of expectations appear to be more common in those with no prior experience of mental health services; however this is not exclusively the case.

*“I mean when I had gone to the Casualty, I suppose my expectations were like chemical, you know, physical treatments.”*

(Brynn)

*“I had expectations. The expectations I had for the first two was just give me a med....a miracle pill and make me feel better cause I feel like crap.”*

(Caroline)

Not all service users are in a position to clearly articulate what they expect in any more detail than knowing that they are expecting to be helped.

Having, in most cases, acknowledged a level of psychological distress, either by seeking help through statutory services or accessing the ED following self-harm, the service users are then in a position to potentially access the LMHS. As will become apparent in the next axial code there are still more barriers yet to negotiate. The assistance of informal carers may play a part in helping the service user to navigate into the LMHS. At this point, it is important to note, in their treatment journey the service user has a level of psychological distress which places them at increased risk of potential or further harm.

The routes into LMHC are complex and involve confusion about where to go and how to access help. Pre-conceptions of what might happen to them affect how service users feel about presenting for help. There is a sense of helplessness for those who do not know where to go and/ or fear about what might happen if they seek help for their psychological distress. Alternatively the LMHS represents a known safety net at times of crisis. Once service users are referred or refer themselves to the service they face challenges in getting to see the service. Once the service user reaches the ED or asks for a referral on an in-patient ward they may then find that access is difficult or blocked as is discussed within the next section. The level of psychological distress the service user feels is often represented by a sense of hopelessness.

### **6.3.2 *Into the Emergency Department and the Liaison Mental Health Service***

This axial code, '***into the ED and the LMHS***', sets out the issues which affect the service user as they attempt to access the LMHS. It identifies the potential barriers which may impact on successful navigation of the service, including the effect of the therapeutic engagement once contact with professional services is achieved. Service users reported the need to feel that their psychological distress was being taken seriously. In this section potential ways that LMH professionals can conduct the assessment process, at this critical juncture, in order to personalise the interaction and validate the

distress for the service user, therefore leading to potentially improved outcomes, are presented.

Once the service user attempts to find psychological help certain things can occur which present a barrier to achieving the help they anticipate. Many spoke of the experience of encountering **negative attitudes** from professionals. The experiences can be very negative and make service users feel very angry about the attitude professionals have, which from the service users interviewed, relates primarily to experiences with non-mental health trained professionals. One lady (Janice) who regularly attends the ED for mental health issues finds that because she is now familiar and well known at the ED, even when she has come about her physical health condition, she receives a negative response from the ED staff. She feels that she is not taken seriously and that this is because they see her as a mental health patient.

There were, however, service users who anticipated a negative response because they had taken an overdose, but were pleasantly surprised that this was not the case. For example, coming to the ED having taken an overdose on New Year's Eve and expecting the healthcare staff to be resentful of the time being taken to care for someone who has self-harmed. The staff were not as expected and the service user found them to be very supportive and sympathetic towards his situation and distress. Another service user (identified here as Kevin: see extract below) left the department during his

treatment for an overdose and expects the staff to be angry when he does return, however that was not his experience.

*“I've quite literally sort of sat down and taken a whole load of tablets and.....it could be understandable to have some kind of sort of.....annoyance of that you know having to sort of treat someone who's done that to themselves when they could be treating some, um.....um someone that's just come in from a car accident or something, whatever, um but no they were very good, very kind and and, and, and just made it very clear that they would like to help me get well.....and to go home which was good.”*

(Kevin)

If **presenting out of hours**, help from the LMHS may not be available and can lead to service users leaving the building, without obtaining the help they feel they need. There was an identified gap in the service that existed from late evening (9pm) until working hours (8am) the following morning. For the service users for whom this occurred it had very serious consequences, as they describe leaving without obtaining mental health assessment or any mental health care being provided to them, reporting how this had a profound effect upon them. For example, one service user (Mark) describes a deterioration in his psychological distress to the extent that he loses his job, the chance to continue with his studies and his marriage fails. The service user who latterly loses his job and relationship on account of his mental

distress wants to receive psychological help, and there is a barrier created simply by the time at which he is taken to the ED, late at night.

Another service user (Evan) was driven to take a further overdose as a means to 'prove' that he was not well and should receive care, (although the care in this instance that he wished to receive was physical not psychological).

*"I did it here to prove a point [took another overdose], to say I wasn't feeling well. I was going home, I couldn't walk more than a few chairs. I have to sit down, something is definitely wrong , this is a man who can walk and walk and walk, so I come back and ask them to let me see a doctor and they said sit down. I waited twelve midnight to nine am, other people coming in and seeing a doctor. I took them [tablets] to get the doctor to see me. Then they say I'm not sick, it's my body I know how I feel. That time I wasn't thinking about it like I was before. I wanted to show the doctor things can happen and you don't know."*

(Evan)

Evan has clearly been seen in the general hospital for a physical health issue and was then moved into the mental health services. He took an overdose in order to get the medical team to listen to him, when they discharge him home and yet he is not physically recovered from his original medical issue. He uses the overdose to attempt to have his physical distress acknowledged and investigated further. His first encounter, where he is not prioritised and leaves without being seen, does not suggest that his attempts to communicate his distress are being successful; rather that he is being further

ignored. He decides to escalate the situation by taking a second overdose which is more serious and leads to an admission to hospital. At the time he was interviewed he was an in-patient in the general hospital, following his overdose, therefore it was unclear if his dangerous strategy worked and if he received further medical help for his original physical health issue.

Another barrier to successfully accessing the LMHS occurs when service users ask to see a liaison nurse or a psychiatrist, yet this is either not communicated to the LMHS or resources are not available to offer a service. Service users interviewed were able to identify missed opportunities where health care professional, including LMHS, could have intervened to offer help but did not. This leads to the service user feeling that they were not worthy of professional help and adds to their sense of helplessness, this is illustrated by Brynn,

*“Before I was discharged from hospital, the doctors on the ward kept saying to me “You will see a psychiatrist before you leave”. (**Right**). but I never did. (**You didn’t**). And when I didn’t they said “ You will be sent for an out-patients appointment for hospital L”, but I never was.”*

(Brynn)

#### *6.3.2.1 Barriers and blockages to access of the LMHS: the physical environment*

**Where** and for how **long** the service user is expected to **wait** for help can also affect their ability to **negotiate the system**. When psychologically distressed having to wait in the main ED waiting area can be very



challenging for service users. They feel uncomfortable with how their own distress might affect others or how their distress is increased by the sometimes chaotic nature of the waiting room. Service users will at times alter their behaviour to try to amend the response they are getting when they are waiting to be seen and assessed. The service user may perceive that **who they have come with** is also potentially having an impact upon how they are treated.

One service user (identified here as Gill) feels as though she is "in a goldfish bowl" when she is waiting (in the main waiting area) to be seen, she is unhappy and feels that her distress is not being acknowledged. She feels able to work the system by "acting out" to get herself moved to a more quiet and private situation.

*"I was basically sitting around looking very, very miserable, and like scaring all the other people and my boyfriend was running up and down to the nurses saying, "Look when are you going to be seeing her?" and I would be standing up and going, "I'm going", and then he'd have to try and loudly persuade me to kind of sit back down again and wait and stuff and I was crying and curling up into a ball and all the usual stuff that people do when they are in a really bad state."*

(Gill)

Gill identifies that she has insider knowledge that this might work because she is involved in healthcare. Being asked to wait in the main waiting room is

perceived as a dismissal or lack of acknowledgment of the level of psychological distress the service user feels.

Arriving out of hours (9pm to 8am weekdays and 9pm to 1pm at weekends) when the LMHS is unavailable affects successful navigation. Service users who arrive after 9pm may have to wait until morning to be seen, this is very challenging and this is when waiting can become unbearable and service users leave without treatment.

Mark, a service user with a number of presentations to the LMHS, finds that on his first presentation, (which took place during out of normal 9-5 service hours), reports that no one came to talk to him, so he decides to leave, as for him this was an indication that nobody seemed to care about his situation, or circumstance, and thus he feels completely disregarded. There was for him, a complete dismissal of his psychological distress, so he himself seeks to disappear.

*“[I] was taken from Bank A in an ambulance to the A and E at Hospital O and it must have been about nine or ten o'clock in the evening (mmm) and for the first fifteen minutes I was given close attention, I was signed over by the ambulance crew, um one of the nursing staff there, I don't know, who what her status was, brought me a cup of tea and asked if I was Ok but it er, in the long run I spent about five hours there (right) and was eventually left to my own devices and finally just*

*wandered out of the door and went home .... I sometimes thought if if someone could have actually have seen me on that first occasion (mmm) you know and not, if I hadn't been left to wander out (mmm) and ruin my life (mmm) and to get into all kinds of difficulties and, if if I could have talked to someone and could have been brought to realise I've got a problem I need to deal with."*

(Mark)

The system is negotiated more effectively when he comes in with a colleague who stands there and provides what he feels is some gravitas to the situation. He believes that this enables him to be seen and his distress taken seriously. At the point of intervention by the person accompanying him he is still attempting to negotiate his access to the LMHS. Therefore, **who is with the service user** if they present through the ED can affect how they feel they are subsequently dealt with. Informal carers can advocate on their behalf, with one service user (Olivia) describing this as "agitating" on her behalf.

*"I came in and I sat down in the waiting room and there were some other people coming in and out and my husband went to the desk and I presume asked when I was going to be seen and I just went to sit down and wait because he was quite anxious about me being seen quickly it kind of took the pressure of me and I just thought I'm going to sit here, because he is going to agitate them, although I wouldn't have agitated them anyway because,...because, I just wanted, I knew*

*I would be looked after. I just came in and sat down. I have been through it before, so I just came in and sat down and waited.”*

(Olivia)

Being moved from the main waiting area to a room within the inside of the ED is perceived as being the first concrete sign that the psychological distress is being taken seriously. It is a very practical action which is often the first validation for those who come in via the ED that they have been taken seriously. Those who do not or cannot be moved from the main waiting area, for example perhaps because the quieter room is already occupied by another service user find their psychological distress exacerbated by waiting in the main waiting area.

#### *6.3.2.2 LMHS assessment : impact and implications*

For some service users seeking help via the ED is their **first experience of mental health services**. Whatever the professional opinion of the severity of their psychological distress following assessment the way that the service user is cared for at this time will have a potential impact on whether they engage with services in the future. This first contact experience can form an opinion that they do not find the services helpful, available or useful.

When the LMHS is introduced to the service user and assessment of the help needed begins there are a range of experiences from supportive to unsupportive related to a number of issues including having the **opportunity and time to talk**, feeling they are believed and receiving a **sympathetic hearing**. The service user requires **opportunity and time to talk** about their

situation. Some service users are aware that the opportunity to talk is a service offered by the LMHS and seek out the service specifically for that purpose. In the case of in-patient service user interactions this can be about wanting to continue a dialogue that has begun with an initial assessment. Others are surprised that having the opportunity to talk is available, especially in the ED; this is significant for those who are having their first experience of mental health care. The desire to be allowed to tell their story is very strong for some service users.

*“...someone who you might not know, you believe that you will not be seeing again ... I believe a lot of people would get a lot [from] opportunity to explain and say the situation they're in.”*

(Fouad)

Talking to the more anonymous and unknown LMHS staff can allow service users to open up in a way that they cannot open up to their friends and family. For another service user it is the facilitation or bringing together of the service user and their significant other to talk in a safe environment that really helps their situation. When the opportunity to talk is not there, is brief or seems forced - e.g. clock watching on the part of the professional then the service user finds the experience more negative.

*“... the things that I'd say that are weak points is just that sometimes for me particularly, I am very aware whether somebody is looking at their watch to see how long they've got to talk to me and things like that would irk me or probably anyone else really because you want that time just to get the most (inaudible) and sore point at that moment*

*out and if someone's looking at their watch, I sort of get pissed off really.”*

(Caroline)

When the conversation occurs the service user is hoping to receive a **sympathetic hearing** and to **feel believed**. Being supported to get to the root of the problem is important, as is the practitioner skill of listening to the person without judgement, which in turn allows the service user to trust the LMH practitioner and to open up, one service user describes this as ‘letting go’. As the service user feels able to talk then a dialogue develops, allowing service user space to reflect on the problem and at the same time to begin to consider advice and support which will eventually develop into a clear outcome and plan. The opportunity to talk and a sympathetic hearing can prevent further harm by starting a process of becoming more hopeful.

Expectations play a part in whether the service users feel believed, and how difficult issues that need to be tackled are handled, such as problem drinking. Tackling these issues in a way that offers a rationale as to why they are important to the overall wellbeing and circumstances helps the service users to be honest.

*“things were explained to me, for instance when they asked about the drinking (mmm) they said this isn't because we're going, we want to send you away and say you're just drinking, they explained that it was because they wanted to, they were concerned about my medical care as well as my psychiatric care and that was good because I I, my*

*thought this looks bad, you come in and you say oh I've been drinking for thirty days in row (mmm) .....they could quite easily say, say well that's your problem go sort that out (mmm) and that that that was a source of anxiety for me."*

(Mark)

Service users are searching for validation in their interactions with the LMHS and asking questions about issues of risk, (such as suicide) can convey the message that their distress is being taken seriously. Not all interactions lead to this sense of sympathy and validation. There are service users at the opposite end of the spectrum who present and do not feel validated or taken seriously and they are unable to navigate in to or negotiate that which they expect to obtain from the service. The expectations of service users who have this experience are the same they are seeking medication to calm them down (diazepam), their rationale for requiring it are very different but they are not taken seriously, their expectations are not met.

#### *6.3.2.3 Assessment: collaboration or disengagement?*

The majority of the interaction and involvement of the liaison service is taken up by the assessment and in order to be of help the service user needs to experience the assessment as a **therapeutic** intervention in and of itself. There is much variation in the experience of assessment. Service users had very positive experiences and others negative, with some having both, where they had attended the service more than once. The assessments took place in a variety of settings some were detailed and others were quick.

Interestingly several service users spoke about the shock they felt at some of the questions they were asked particularly when the assessment was about getting to the bottom of why they had self-harmed and whether they were at risk of self-harming again, or whether they should be admitted to hospital. The importance of these questions cannot be underestimated because, as discussed in section 6.3.1 pre-contact and elaborated in section 6.4 the core category, so many of the service users are at risk of potential harm to themselves. However one service user (Brynn) talks about feeling that in a second assessment this was glossed over, he hints that this was not covered in enough detail and that if it had been that the consequences of the assessment would have been different, believing that it may have led to an admission because when he next saw a psychiatrist at a routine out-patient appointment he was admitted.

A very practical and important intervening condition in the process of interaction with the LMHS is that of **keeping the person informed**, and also their carer(s). The impact of **waiting time** and **where you wait** has already been identified and links to this concept. It became apparent to the author when she first began contact with LMHC, through non participant observation and later induction for clinical practice, that waiting has a profound effect on the service user it links to not only the concept of **feeling believed** and the validation of the psychological distress but it also can aid or abet the navigation of the service user through the system. At any point in the process when things are not progressing at the pace the service user is anticipating this can lead to frustration and concern on the part of the service user and or



their carers. Why people are waiting and realistically when they might be seen is vital to convey to the service user and carers. As the professional we hold all the information, we are clear what we are doing and why, most of the time, but the way we communicate this is of paramount importance. For example to use the term “in a minute” one favoured particularly in nursing, i.e. I will see you in a minute, a phrase that frequently in the author’s practice and one which a service user (Patience) makes direct reference to being used in communication with her. “In a minute” is almost always unrealistic and a platitude rather than a realism.

Throughout the service users’ time in the LMHS, whether it is in waiting to gain ‘admission’ into the service or during assessment where information is being obtained elsewhere or planning is being undertaken, there is a need to inform service users and carers of the realistic time frames. Resetting the clock and offering an explanation when things are progressing more slowly than expected can make the difference between someone waiting calmly or in a distressed state or leading to the more serious consequence of the service user simply walking out before any assessment and plan is complete. The potential for harm in all these situations is increased because the person has not been **kept informed** and the message that this conveys is that they are not behaving in such a way as to justify the attention of the LMH practitioner or service. As the assessment progresses keeping the person informed and offering a **transparent process** serves to ensure that the service user does not feel forgotten or abandoned and is aware of their progress through the assessment. This has a positive consequence,

conveying that their psychological distress has been accepted, identified and a potential to solve the problem is available, this leads to a positive **outcome**.

#### *6.3.2.4 The essence of a therapeutic assessment in LMHC*

There is a thread in the service users' stories regarding the need to explore issues enough to understand the individual's needs and problems, primarily this comes to the fore when the assessment or the outcome of the assessment doesn't make sense to the service user or doesn't seem to have the right focus. Again service users making this comment are reflecting not just on the single LMHS assessment but comparing it to a number of LMHS assessments or assessments by other mental health practitioners. This is about making sense of what is being discussed and fits with the idea of person centred care. The assessment does not appear person centred for a variety of reasons, including previous history not being taken into account and applied to the current circumstances, a sense that the assessment is superficial, that normal behaviour for an individual is taken to be abnormal and incorporated into the diagnosis - unfairly so from the point of view of the service user.

Assessment is a positive experience when the service user can make sense of why certain questions are being asked; either this is obvious to them or this is explained directly. The process then makes sense and there is a meaningful dialogue achieved. The importance of assessing risk is identified by service users as an integral part of assessment and if this does not seem

to be covered this leads to a poor experience. The importance of engaging and supporting the service users significant others through the assessment can make the difference between a satisfactory or poor experience. In exploring and reflecting on their experiences service users can identify the essence of a therapeutic assessment. The aspects of a therapeutic assessment, as identified within the service users narratives, are illustrated and represented in Figure 6.3.

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## THE ESSENCE OF A THERAPEUTIC ASSESSMENT

Service users identify the following factors as important :

### Process

- making connections with the person
- explaining why questions are being asked
- taking the person through a process
- giving the person a sense of where the assessment is leading
- going at a pace where the service user can keep up
- questions might seem harsh and may need to be very direct
- involving the service user in the decision making
- balancing quickness and thoroughness

### Content

- having the ability to ask the right questions
- Knowing the person's history
- accounting for and exploring the person's history in the context of the current problem
- understanding the essence of the person
- risk assessment/ harm to self or others is covered
- including physical as well as mental health
- standardised questions - not always liked and need to be personalised
- conferring with other professionals
- conferring with significant others to understand the background and to check out assumptions about what is normal and abnormal for an individual

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**Figure 6.4: The Essence of a Therapeutic Assessment in LMHC**

Finally, the experience continues to be a positive one if the service user is helped to understand the psychological crisis they are in, and how this is explored is presented further in the next section. In conducting the

assessment the LMHS needs to demonstrate that the **background and history** has been taken into account. This can have various consequences for the service user, it can prevent them from having to explain aspects of their history which are already documented and more specifically actually known by the person they are seeing, service users can see value in seeing the same person again when they attend more than once, however LMHS are not set up to accommodate this approach.

The service user (Janice) who attends regularly for support does not book herself into the ED unless she knows that the person who has a long history of caring for her is there and able to see her. In other situations the knowledge of history can confer thoroughness on the part of the practitioner showing that they are considering the wider picture. Service users identified attributes of the LMH professional including how they conducted the assessment; furthermore they perceived that if they had accessed a professional who had the right **clinical knowledge** and attributes to conduct the assessment then the outcome was positive.

Service users navigate into the LMHS through a variety of routes. Once referred to the service they are expecting to be seen in a timely way and to wait in a calming efficient, and welcoming environment, which will not exacerbate their distress. Once the interaction with the LMHS begins the service users have expectations of what and how the assessment process might ensue, and also that any delays will be communicated effectively to

them. Not being kept informed can lead to a variety of consequences for service users, including the deterioration of the mental state and increased distress, leading to greater risk of self-harm.

When service users meet with a positive response from the health care professionals they are surprised at this response. The interaction with the LMHS may be their first experience of mental health services and can therefore have the potential to impact on future engagement. The process of the assessment and the decision making about an action plan needs to be a transparent process that engages the service user.

### ***6.3.3 Outcomes of using the liaison mental health service***

The third axial code is that of outcomes. In this code service users explore what constitutes an effective outcome. Findings are presented as a jigsaw of three pieces: Acknowledging distress/ Mental illness/ Diagnosis, Symptoms and Coping strategies (Figure 6.5). If the interaction with the LMHS serves to help the service user fit the jigsaw together, then the experience is a positive one.

#### ***6.3.3.1 I have a plan....or not?***

Various outcomes were identified; one is that the service user is provided with **another perspective** about their situation. For some service users' validation of their problem is not entirely established **because they are**

**believed** but is found when they are able to **attach labels to problems**, and for some service users this is in the form of a formal **diagnosis**. The interaction with the LMHS offers time to help the service user with a number of related issues. When service users present to the LMHS the commonality is that they only have, at best, part of the information that they and or their carers need to understand their situation. In essence they have only some of the pieces of the puzzle or jigsaw which makes up a complete understanding of their psychological distress. There are three aspects to the jigsaw which can be provided by the LMHS. Each piece will be of benefit to the service user but only if they already have the other pieces. Alternatively if they leave without the jigsaw pieces the referral onwards must serve to provide more pieces of the jigsaw and help the service user fit them together. The three aspects are firstly that the problem comes under the broad heading of mental health, this attaches a primary label to the problem and may come in the form of an actual or provisional diagnosis and names the psychological distress, some service users already know that their distress has a label and that this is for example, depression but have not made the connection that this is a mental illness. The concept of the jigsaw is illustrated in figure 6.5.



**Figure 6.5: Making sense of psychological distress in LMHS.**

The second piece of the jigsaw, and arguably far more useful for the service user is an understanding of which aspects of their current experience of psychological distress and its consequences can be directly linked to the attached label. From a professional point of view this is explaining the symptoms or experiences encountered when one has the specific mental health issue. Thirdly the jigsaw includes the strategies that each service user can apply to manage the psychological distress. In the interviews undertaken and the varied experiences it is the psychosocial interventions and not the chemical ones which service users talk about as most helpful. These



psychosocial strategies are referred to by the service users primarily as coping strategies and this is a term that we as professionals are familiar with.

Leaving the LMHS having been provided with only one or two pieces of the jigsaw is unsatisfactory, unless the service user can clearly see where they are going (referral) to obtain the next piece of the jigsaw. However if the LMHS is able to help the service user fit into place the final piece of a jigsaw then the impact is profound and the service user is very satisfied and positive with the outcome. Service users describe this positive outcome in terms of the LMHS helping them to think in a deeper way about the causes and coping strategies available to them, they feel able to understand their psychological distress more clearly.

Reading and reviewing the service user interviews, it was rare that the LMHS was able, within the limited time available for assessment and planning, to offer all the pieces of the jigsaw and therefore help the service user to piece these all together. What the LMHS may only be able to do at this point is to refer the service user onwards, to another agency who can help to complete the jigsaw and ultimately find a satisfactory outcome.

A relational consequence is that the service user is able to move from a state of **hopelessness** as described in section 6.3.1 at the beginning of the findings, to one of **hope** and optimism. This only occurs if they have a clear sense of where things are going and the service user has been able to find

someone who engages them and enables them to feel helped. Expectations are exceeded, for example through psychosocial interventions, alternatives to feared options such as admission to psychiatric hospital are offered. Alternatively admission is right and needed and provides the service user with the help that they need leading to a feeling that they may be able to lead a normal life when thinking about discharge from hospital. Thoughts of harm are reduced and the desperation evident in the **pre-contact build up** to entering the LMHS is alleviated.

#### *6.3.3.2 Provision of a safety net*

Having a clear **action plan** is key to the service user **feeling** that the intervention of the LMHS has **helped** them. Interventions that aid this process are: **liaison with other services, being offered follow-up** and **local knowledge** on the part of the LMH team member which leads to referral to appropriate services. Follow-up is not formally offered by the LMHS involved with the service users, although it can sometimes occur informally. From the service user perspective follow-up as a formal option seemed a logical and lacking aspect of the service and one that could clearly improve the safety net available to service users. One service user identified that he would have like to return and understand more about why he had felt the way he felt and taken the overdose but this follow-up was not available. Contacts for local self-help organisations and voluntary organisations were identified as lacking in terms of the information given to service users who had contact with LMHS. Outcomes for service users lie along a continuum can involving many options including admission to hospital. Others enter

feeling dependant but are supported during the time they spend with a LMH practitioner to a point of greater self-reliance and ownership of their problems requiring no referral onwards. The therapeutic nature of the engagement leading to positive outcomes that aid recovery is very well articulated by the service user who is initially seeking a 'miracle pill' to make everything instantly better but leaves her final visit to the LMHS with a very different outcome but one that she finds far more effective.

*"The third time ... I didn't feel as if I was getting any better and the fear was beginning, I felt [It] was beginning to intensify and so I wanted something that would make me feel better automatically and what I got was something completely different. So even though I wanted to feel better immediately, mentally and physically, I felt better mentally and physically by talking to someone and trying to, I can't explain it, apply systems or apply coping strategies into my life and actually looking about what was a problem that was in my life rather than the illness being a problem. So that was the difference, whereas with the first it was the illness that was the problem with the third time it was looking at what could be the problems that has made the illness."*

(Caroline)

This quote encapsulates the concept of the jigsaw represented in Figure 6.5 (above). This lady has navigated through the LMHS system three times at the point when she gives her time to the study. Two experiences of LMHC occurred before she met someone who she felt she connected with and more importantly that she perceived to connect well with her, that someone

was then able to offer her a positive way forward. There were times during her overall journey where she had negative experiences and inappropriate prescription of antipsychotic medication and yet she returned and renegotiated her outcomes with the LMHS until she found her “miracle pill” however her “miracle pill” was not in the form of medication but in the form of coping strategies she could apply to her life . She explains that in her previous visits the focus has been the illness (the diagnosis / mental illness piece of the jigsaw), however on the third visit she is able to focus on the effect of the illness on her everyday life (represented by the symptom aspect of the jigsaw) and furthermore she is helped to identify coping strategies which work for her (the final piece of the jigsaw).

Public access to the ED and/ or a knowledge of LMHS in the general hospital acts as a **safety net** for service users. Those who have had previous experiences know that the service exists and whilst **never wanting to use the service again** they find comfort and **hope** in the availability of a **safety net** and knowing that they can **return to the LMHS if they need to**. Service users do not want to use the service again because they do not want to be in crisis again or feel the same levels of psychological distress; it is not an expression of a negative or poor experience. As at the beginning, in the build up, there would be other options that service users would make use of before visiting the LMHS, including family and their GP. Take Olivia’s comments for example:

*“The service is useful to me because I have got a mental illness and it is quite good to know that it is there as a safety net if I became acutely ill.*

***Is it your only safety net? Would say that is it the main safety net?***

*No, the GP and my husband and the drugs are my safety net.”*

(Olivia)

#### *6.3.3.3 The referral process: making sense of a safety net*

A positive outcome of attending the LMHS for service users can often rely on whether a referral is achieved. For example, referring the service user back to their own GP, or to an out-patient follow-up appointment. However, service users do not always engage with this follow-up process, either because they feel better at the time the date appointment finally arrives (several months after the initial crisis), or they do not go back to their GP, for whatever reason. For some service users who do follow the advice given and see their GP's they can then be referred for longer term counselling or ongoing psychiatric community based care, some of these options are also directly available via the LMHS. Informing the Community Mental Health Team (CMHT) already involved with the service user of their visit may also be an outcome of attending the LMHS. What appears most important is that these referrals and subsequent actions plans need to make sense to the service user.

Alternative outcomes can be admission to hospital, which may be resisted and use of the Mental Health Act (1983) may play a part leading to enforced admission against the person's wishes. For one interviewee (Donald) this was a familiar occurrence and from the interview seems a reasonable response by the LMHS because he describes serious suicide attempts where he has set fire to himself or tried to jump of a bridge.

#### **6.3.4 A positive experience of LMHC**

The three axial codes describe the journey that the service users experience that leads to entry into LMHC and navigation through the LMHS. In order to want or need the LMHS there is a build-up of psychological distress and the service user tries to manage this by means other than the LMHS. Those who were interviewed were unsuccessful, using their own safety net, in managing their psychological distress and therefore found themselves in contact with the LMHS. In order to have a positive experience of the LMHS the service user will need to feel believed and to have an assessment that takes into account their history.

There is a need for the LMHS to make a personal connection with the service user, in order for this to occur the process needs to be transparent and to offer the service user the means to better understand their psychological distress. The LMHS may be instrumental in helping the service user understand their psychological distress in new ways or to attach labels to it. It is vital to a positive experience that the service user and their carers

have a clear sense of what will happen to support the service user after the LMHS interaction is complete. In order for the service user and their carers to pass through the LMHS they must negotiate and navigate through the various aspects of their distress and the service provided. The next section of the findings will articulate the core category concept of this navigation and negotiation.

#### **6.4 Core category: Negotiating and Navigating the System**

This section seeks to articulate the core category of negotiating and navigating the system. As was articulated within the method chapter (chapter 5) the validating of the category involved working with the supervisor (SH) to ensure that all categories and codes could be linked to the core category. A graphic presentation of the linkages is provided (Appendix 9) to accompany the written articulation that follows.

Service users do not often make use of the LMHS through choice, particularly as at the time of accessing the service they are all experiencing a level of psychological distress that is above that which they feel able to cope with using their normal strategies. This distress can occur in the community or on an in-patient general hospital ward. The normal coping strategies (of seeking support from family and friends) can be unrelated to the mental healthcare system. Normal coping strategies can however, also be healthcare related, for example going to see their GP, or using non-statutory services such as private counselling. Alternatively, these normal strategies

can be part of the mental healthcare system, such as community mental health care or out-patient services. Service users navigate into contact with the LMHS because they know it is available, most often through previous visits and being given the option to return if they need to; or because the service has been recommended by a statutory health service (such as a GP) or a referral is made from within the general hospital team. Alternatively they come to the ED because they do not know where else to go.

The expectations the service users had of the LMHS may be based on previous visits and their experiences or on a personal expectation of mental health services. Some service users claim to have no expectations because they were not aware that the service existed however they quickly develop expectations as they become aware that they are entering the service. Previous experiences and the expectations that develop are not necessarily met in subsequent interactions from the LMHS. This is partly because the service does not offer any consistency of staff across visits. This inconsistency may represent a challenge to service users in navigation and negotiation of the service when they are using the service on more than one occasion.

Gaining access to the right health care, as a recognised 'expert', someone able to identify and deal with the service user's psychological distress requires considerable navigation, negotiation and a sophisticated level of awareness of health professional roles and knowledge of the process. For



example, one service user, Nadia, wanted to see a psychiatrist because she could clearly see that there was an interaction between her physical and mental state. A further participant invokes and successfully engages with mental health care through the act of taking an overdose. He felt he was not being acknowledged and listened too in terms of his physical health care needs, his response was an extreme one, and he is not able to access the safety net of liaison mental healthcare until harm has occurred. Interaction with the liaison team and the broader interaction with all healthcare professionals during an episode of care can have a positive, negative or neutral effect on the trajectory of peoples' mental health and/ or their physical health. This interplay between physical and mental health is one reason why people seek liaison mental health services.

Sometimes service users attempt to access the LMHS but are unsuccessful. Mark described the times when he was either not seen or not helped by the intervention in the ED. Despite this previous experience, he had more latterly been helped, so that he could reflect back on how he thought these early interventions should have been managed better. An improved or more helpful interaction would have included being allowed to talk, therefore getting things out of his system, acknowledging something was wrong, being seen in a timely manner and seeing a (highly) qualified psychiatrist or therapist he saw would have achieved this.

A consequence of poor experiences of LMHS, is that service users are left feeling dissatisfied, disconnected and with as much, or more hopelessness as on entering the service. A positive experience is obtained through the LMH practitioner ensuring the interaction is centred on the individual; connecting with the service user as a person, their personal situation and accepting and listening to their problems, predicaments and concerns. If the expectations of the service user are not matched by the practitioner's approach, the service user feels at risk, and the harm is repeated and/ or their psychological distress increases.

The navigation is not just physical, in terms of finding the service and the right person; it is also cognitive. Service users need support to navigate to a place of understanding what has happened to them and what may happen in the future as a consequence of their psychological distress. The service users try to make sense of what is happening to them, and this appears to be significant. There are a number of service users who found their visit to the LMHS really helpful in terms of helping them make sense of their situation and the problems they have. There are others who point out, particularly in relation to 'potential harm' that either during their visit, or at other visits to either the LMHS or other mental health services, that they could and should have received more help in terms of understanding their particular problem.

Where service users have a more positive experience, they are aided by professional input to make sense of the problem. Being dealt with

personably, being helped to attain a level of understanding about their problem and how to improve their situation, often appears to start with the importance of moving past the giving of a psychiatric diagnosis, and may even be about not focusing on a diagnosis at all. This process appears to occur at the very start of a basic assessment interview. For example Harry is asked if he makes connections from the television. He realises at this point he has done this and this triggers a new understanding of his psychological distress. Evan reports that the assessment and interaction made him think more about what was actually happening. Yet, a positive interaction does not always prevent deterioration; as one service user at a later date went on to harm himself, stating how he did not feel the person assessing him should have foreseen this future. There are limitations to the safety net and ability of the LMHS to prevent harm.

The 'safety net' is an important concept that runs through the whole experience of the LMHS. Some service users interviewed knew about the LMHS and had an open invitation to drop by or call whenever they needed to talk. This level of agreed open access served to help maintain them in the community. It is clear from some of the experiences that the safety net is not only available to the service user but also to the professionals who support them. For example one service user has a long term mental health issue which is managed in primary care, nevertheless there are times when emergency help is required for a relapse and the ED is the safety net for the primary care team. For some service users the LMHS emerges as a safety net only after the initial visit when they are offered the option to return if they

need to and although they hope not to be in such 'dire need' again they find it helpful to know that the service exists and is available to them. The safety net aspect of the LMHS is one to support people in navigating their own fluctuating psychological distress.

There is a desire from service users to seek the right help for a specific mental health problem, however finding this help is not readily accessible or forthcoming through the normal channels, the person becomes negatively affected. Service users identify the negative impacts as breakdown of key relationships, subsequent admission to hospital, taking the wrong medication, or taking medication that is no longer required, and the increased potential for self-harm, even suicide attempts. As a consequence of not being able to negotiate receipt of the service there is an extension of the physical – mental health interactions, issues continue to manifest and not be adequately address, they impinge upon the person for longer than they need to. For many service users the consequences of not effectively navigating the system in terms of the detriment to the mental health is potentially extreme, this memo extract for the category 'potential harm' demonstrates this well.

*"Negotiating and navigating the system - this category [potential harm] shows that if the system doesn't work for the individual and they are unable to navigate through it effectively then the potential for harm is extreme. Numerous service users are seen by the service because they have attempted to take their own lives and one is seen again because he makes another attempt. There are ten service users within this category that identify*

*directly that the potential harm' if things don't get better or they hadn't been able to access the LMHS in a timely manner, is death.*

Coding memo 'potential harm' 12-04-13

The initial interaction between the individual and the wider health care professional team, in particular, how the diagnosis or treatment options are explained, can be a crucial entry point to effective care delivery and a good or bad experience for the individual. One service user finds the first interaction more meaningful than any of the subsequent ones, because he has been told and therefore is aware of what is going to happen. However, on his later visit, he gets no further sense of progress, or any additional information to help him navigate through his journey of recovery. He keeps asking, but nothing happens.

*"The first one I found extremely positive and helpful. And the second one was less helpful. **Right** . Largely I think because it was indeterminate. **Right**. I didn't get any kind of sense of where my case was going to go. **Right**. And or any idea of who I might see next or anything like that."*

(Brynn)

This service user, Brynn, is told that he will see a psychiatrist, but it doesn't happen, his discharge proceeds and as he leaves he is told he will receive an out-patient appointment but he does not. In his interview Brynn explains how he asks a number of times about what is happening, trying to intervene and negotiate with the general hospital staff to gain the input (psychiatric review and out-patients appointment) he knows that he needs. He believes

he has slipped through the gaps in the service because when he goes to his next routine out-patient appointment he is immediately admitted to in-patient mental health services. He reports that if that appointment hadn't been there he would possibly have killed himself. This highlights very dramatically the importance of the safety net that can exist around mental health service users and the part that LHMC has the potential to play in that safety net. However in the case of Brynn the lack of follow-up of his initial assessment on his second visit is a barrier to his navigation through the system.

An adequate explanation of what will happen next for the service user is not always provided, even after a number of visits or interactions. Several of the participants identified this and described how they felt that an additional interaction or intervention might provide the clues to help solve their particular problem. One person took matters into their own hands, in a potentially dangerous way, by taking an overdose, because the treatment or care package was not making any sense to him. Another person spoke of the negative consequences of not getting effective treatment, in that his life 'falls apart'. Eventually he does find someone who helps him understand his mental health problem, but this is not the person in the LMHS, although he is facilitated to meet them on a further hospital appointment arranged by the LMHS.

The key to successful navigation from the service user perspective is an interaction that leaves them feeling that they have been listened to and

understood, that the genuine nature of their psychological distress is acknowledged and that the interaction ends with the service user having a clear understanding of what will happen next and why. If there is no clear outcome from the interaction the service user is left without a clear ending and this increases the potential for further self-harm. Service users will navigate back into the system when psychological distress increases to either obtain further help or to renegotiate the assistance offered previously by the LMHS. Sometimes attempts to negotiate the help they feel they need are unsuccessful and they are unable to obtain the outcome they initially expected, this was the case for service users who wanted follow-up and do not receive it and for others who wanted medication (diazepam) and it was not prescribed.

From a service user's perspective these are negative outcomes if there is not an acceptable negotiation of outcomes. There are times when the expectation is not met but the interaction is still positive because the outcomes are renegotiated and meet the service users' expectations in new and alternative ways. Most service users are reflective of their experience and at the same time critical of the experience, it is striking that even when dissatisfied and unable to negotiate the desired outcome they are able to consider why this might be the case and to recommend how the service could respond differently.

Negotiating and navigating through a complex and often previously unknown liaison mental health care service has been shown to be a core theme in the service users' interviews about their experience of using the LMHS. Having accessed the LMHS, with an unbearable level of psychological distress, there is the potential if the navigation and negotiation is successful to move from hopelessness towards hope. For some service users the prevention of future harm is also an outcome of an effective navigation through the LMHS.

### **6.5 The impact of effective and ineffective negotiation and navigation of the liaison mental health service**

The service users interviewed had navigated into the LMHS because they had experienced a level of psychological distress that they could not resolve using their existing personal resources. This psychological distress may have led them to self-harm or to fear that they might do this. At this point, before they are able to access the help of the LMHS, they are feeling hopeless about the situation. When it is acknowledged that they need help, service users want to be kept informed of how their referral is progressing, and if in the ED, to wait in a quiet place.

For an assessment to be effective service users need the opportunity to talk at length and to receive help to unpick the psychological distress and to understand what it means in terms of possible mental illness. There is a need for the LMH professional to make a good connection with the service user to enable this process. Leaving the experience with a clear action plan



that makes sense in the context of the psychological distress the service user has felt is important to the success of a LMHC intervention. If the interaction with the LMHS is effective and the service user negotiates a satisfactory outcome rather than remaining hopeless they leave with a greater sense of hope about their situation.

## **7 DISCUSSION**

In beginning the discussion it is perhaps useful to return and be reminded of the study objectives in order to make clear the progress that has been made in addressing each of them.

### **7.1 Study Objectives**

The objectives of the study were:

1. To critically consider the impact and implications of research (1975 – 2013) and policy development (1990 – 2013) in the area of Liaison Mental Health Care.
2. To use constant comparative analysis, an aspect of grounded theory, to analyse and present experiences of liaison mental health care service users.
3. To identify and discuss theoretical understanding of the experiences of mental health liaison service users from a case study site in inner London.
4. To provide policy and practice improvement recommendations for contemporary liaison mental health based on the application of findings from the study.

The first three study objectives are considered in turn as a means to focus the discussion. Based on these discussions, and the devised conceptual map of the service user journey created from the study findings (Section 7.4 below), objective four, recommendations for policy and practice improvement for contemporary liaison mental health, is presented in Chapter 8, recommendations.

### ***7.1.1 Impact and implications of research and policy development in the area of Liaison Mental Health Care (1975 – 2013)***

The research and policy context were identified and considered in chapter 3. The international literature on the structure, process and outcome of LMHS was critically reviewed both at the start of the study, and as a second phased approach to update understanding. The available literature is diverse in nature and as a consequence drawing conclusions or identifying a clear development in the evidence base for LMHS was challenging.

Over this time period, there has been an increase in research in Australia, particularly in the LMHN field, and an apparent reduction in research in the USA. The UK has also seen a reduction published research from 2003 to 2009, with a resurgence building with recent publications incorporating economic evaluations.

At the beginning of the study few published studies were identifiable that explored the experiences, expectations or satisfaction of LMHS users; this remained the case up to 2013. Research suggested that in Australia and the UK LMHS continued to develop on a very individual and local basis, responding to local requirements rather than a national policy direction. Over the course of the study UK guidelines on the provision of LMHC have proliferated; however there remains no consensus, quite possibly because

the evidence base is lacking, of how LMHS should be configured and what their aims and objectives should be.

A recent UK government strategy to ensure mental health issues are considered in all health care (HM Government, 2011) has led to a renewed interest in the provision of LMHC. Recently published reports have suggested that there may be an economic case for LMHC. Another recently developing strand of UK government healthcare policy is the need to improve the patient experience and to better incorporate patient reported experience measures into the evaluation of healthcare delivery. Without knowledge of the experiences of LMHC service users or their evaluation of LMHC delivery this will prove challenging.

### ***7.1.2 Experiences of liaison mental health care service users***

The findings of the constant comparative secondary analysis of 17 LMHC service users were reported in Chapter 6. In broad terms, the exploration and theoretical analysis of experiences of people who had used liaison mental health services revealed that service users had varied experiences of LMHC, some effective and satisfactory and some not. The build-up to seeking support from a liaison service was seen as an important aspect of the service user's journey and needs to be considered within the provision of LMHS.

Service users reached a level of unbearable psychological distress before they accessed the LMHS via a direct presentation to the ED or making a request to see a LMH professional or before a recommendation that they seek help from the LMHS. If contact was made through the ED the initial reactions of the ED staff affected their willingness to engage and extended waiting times or a lack of information affected whether they waited to be seen; when they were accompanied to the ED, the ways in which carers were treated also had a similar impact. General hospital staff need to have the skills to identify psychological distress and to support the service user until the LMHS is able to assess them. Once they enter into the LMHS service users firstly need the opportunity to talk and in doing so feel that they are believed, the assessment needs to be sympathetic to the individual service user and also communicate a level of competence to the service user on the part of the LMH professional.

Service users welcomed help to understand their psychological distress and to develop their coping strategies, and expected to receive a clear action plan that was meaningful to them as an individual. The LMHS represented a safety net for service users and had the potential to reduce the likelihood of actual harm. It also had the potential to help service users' move from a feeling of hopelessness to one of hope.

This chapter now moves on to consider theoretical perspectives on the core category identified in the analysis. The experience of LMH service users from

a case study site in inner London was theorised and this process revealed a conceptual map of *The Service User's Journey Through LMHC: negotiating and navigating the system* (Section 7.4 below). The articulation of the development of the conceptual map is the basis of this discussion. Recommendations for policy and practice improvement for contemporary liaison mental health, based on these findings, and the conceptual map of the service user journey are presented in Chapter 8.

## **7.2 Setting the scene for a journey through liaison mental health care**

The discussion that follows has a number of aspects; firstly the core category of negotiating and navigating the system is revisited and discussed. This is followed by a consideration of how the literature regarding health care experiences of service users who self-harm and the broader literature on service user health care experiences links to the main themes of the data analysis. There then follows a discussion of the conceptual map developed as an outcome of the data analysis.

### **7.2.1 Theoretical findings as core category: *Negotiating and navigating the system***

The findings of the study identified the complexity of the service user experiences of LMHC. The core category attempts to articulate that there are many barriers and obstacles to be negotiated in gaining help when psychologically distressed. The core category of negotiating and navigating is about the experiences of service users who have moved from a level of

unbearable psychological distress to a successful outcome through access to a LMHS. The premise of this discussion and the theoretical perspective taken through the core category is that service users are relied upon to navigate into and negotiate through to a successful outcome.

The argument presented is that too much emphasis is placed upon the service user and their carers to understand where to go and at what point to access services, it is as though the service user themselves should be able to assess their appropriateness for services, that is if they can identify which services they should access and if they do not make the right decision at the appropriate stage of their psychological distress the professionals considers the service user to be at fault. The LMHS at its best offers a means to obtain relief from the psychological distress, if the service user is listened to and helped to identify actions.

Barriers to negotiating the service include health care professionals' level of awareness and knowledge of mental health issues and also the relationship to physical health problems. For some service users it is only after a number of failed attempts to seek support that they are able to navigate to a successful outcome from LMHC. A successful outcome is dependent on numerous variables including whether the outcomes make sense and are accessible to the service user in a timely fashion. Service users can access professional resources to make sense of their distress; however other sources of information and support may prove useful.

### ***7.2.2 The need for accessible resources to inform the service user's journey***

The terms 'negotiating and navigating' are rarely used in the accessible, public literature on the service user experience. This study indicates that it may be a useful framework to help service users to understand the processes of care. The one website where the term negotiating is adopted is the health talk online website ([DIPEX 2008](#)). This website offers an accessible set of resources to those who wish to know more about specific conditions and the services and treatments related to them. The website incorporates two specific mental health issues, depression and schizophrenia. Information was taken from interviews with service users about their experiences of their health issues and used these directly to help people understand aspects of care and also provides detailed descriptions drawn from a constant comparative analysis of the data collected.

A broad heading of "negotiating the system" is used for the section which deals with treatment options and available services for mental health conditions. Zeibland and Herxheimer (2008) explained that the organisation of the information and the themes used to present the information on the website were taken from a detailed constant comparative analysis (Corbin & Strauss, 2008) of the interview data. This grounded theory approach to analysis of service user experience data from these areas of mental health service user experience (depression and schizophrenia) provided a key



theme or category which is used to structure the content. In the current study's data analysis negotiating and navigating was independently identified as the core category. The mental health service users in the DIPEX study were identified to participate based on the mental health diagnosis unlike the current study where the service users were identified because they had experience of a specific service, so the service users in the current study have experiences of both depression and schizophrenia but also other mental health diagnosis such as Bi-polar disorder. The current study findings suggested that negotiating the system is a core theme for service users with a wider range of mental health issues.

The usefulness of this type of accessible information was summarised by Ziebland and Herxheimer (2008),

*"Illness is a foreign country. Many people need a guide and translator – especially in the early stages before they become acclimatized. Health professionals sometimes fulfil this role although often patients often [sic] feel that only others who have been through what they are going through can really understand and guide them."*

(Ziebland & Herxheimer, 2008 pp439),

This quote touches on several issues pertinent to the current study; it acknowledges that for many the experience of psychological crisis is unknown and unclear – the notion of it being "foreign" and that it requires interpretation and guidance. The current study findings suggest that this

interpretation is best achieved via a variety of sources and this takes us back to the jigsaw (figure 6.5) and the concept that understanding is reached only when a number of pieces slot into place. Figure 6.5, developed from the findings, proposes that the jigsaw pieces include attaching a label to the psychological distress, understanding how experiences link to the label and identifying coping strategies to help manage and limit the distress. Fitting the pieces of the jigsaw together helps the person to make sense of the psychological distress and ultimately to manage it, therefore allowing the person to move to a place of hope.

The current data did not include any example of service users utilising on-line resources to obtain information and the quote above suggests the possibility that over time the accessibility and awareness of on-line resources has increased to a point where service users have greater instant access to personal experience information. That is not to say that the service user accounts have not been available for much longer in print (for example Read & Reynolds 1996) and that self-help groups and organisations (for example Mind and Rethink) have not been there to support people. However the internet has created another dimension, one of immediate access for those in a psychological crisis. Service users can now more readily access information from those who have similar experience in order to help them to slot the pieces of the jigsaw together and as such the DIPEX project and the accompanying health talk online website represents an important tool that service users should be made aware of and encourage to access in helping them to make sense of their psychological distress and to help them to

understand the healthcare system that they must negotiate in order to navigate their journey towards recovery. Hence it is recommended that links to patient experience websites should be incorporated into the patient information leaflets that good practice determines should be provided to all service users who access LMHC (PLAN, 2011).

### **7.3 Conceptualising data; literature on service user experiences and the relevance to the current findings**

The literature review, Chapter 3, set the scene by providing an overview of the literature on service users experience of healthcare. Searches that have continued over the course of the study failed to identify a substantive literature on the experiences of service users of LMHC. What does exist is primarily in the form of unpublished data, and where information is included in published evaluations it is primarily from survey design and therefore does not provide an in depth view of service users experiences. Surveys that were found aimed to consider the satisfaction of service users with LMHC and offered little insight into the experience and the journey which this study seeks to explore. Therefore the search for relevant literature was expanded to consider that of those who self-harm. This is the group that match most clearly with the service users of LMHC. Whilst those who have self-harmed and present to the ED should go on to LMHC according to the literature not all of them did (Bennewith et al, 2004); possible reasons were because either services did not exist in the ED, the referral was not made or the person left without accessing the service. Only ten of the service users who were included in the current study had self-harmed at the time that they were seen

and self-harm does not represent the full remit of the LMHS case study site, nor does it reflect the role of LMHC in its entirety as discussed in the overview of LMHC earlier in the literature review. In considering the literature on self-harm experiences in the ED we would expect there to be differences, with only some of the experiences resonating with those service users with more varied experiences of psychological distress and who have all accessed LMHS.

### ***7.3.1 Mental health service users who self-harm experiences of service provision***

Palmer et al (2007) identified information giving and communication from their survey of service users. They reported that if service users were not kept informed whilst waiting in the ED they might choose to leave and take their own discharge before the outcome of any assessment was known there are similarities to the potential harm construct in the current findings. The potential harm was also evident in service users who did not present with actual self-harm in the findings of the current study. A key expectation of the service users was the opportunity to talk and Palmer et al (2007) also use the term to code their service users' experiences when looking at positive experiences of a full psychosocial assessment. The resonances from Palmer's survey with the detailed interviews undertaken for this study are noteworthy, which lends weight to the idea that the theoretical underpinning of the core category would resonate with service users on a wider scale than this one case study site. The service users voicing their experiences in Palmer et al's (2007) study were speaking in 2006. This perhaps indicated

that there has not been a noticeable improvement in the experience from the time of the interviews for the study presented here to the Palmer et al study (2007).

The question that arises is: why then do we not provide a service which consistently meets service users' requirements and leaves many feeling unable to negotiate an effective outcome to their presentation? The responses of the *Better Services for People who Self Harm* study (Palmer et al, 2007) was the engagement of individual services to develop their specific response to self-harm presentations in the ED. The current study findings suggest that the experiences of those who self-harm are not unique. The current study shows that all service users in psychological distress who access the general hospital need to feel believed, and have the opportunity to talk and yet there were aspects of the development and provision of services that mitigated against this being the experience for some mental health service users who were accessing LHMS from within the ED and the wider general hospital environment.

The review of policy suggested that this may be because until very recently the development of mental health friendly services in the general hospital including the ED has been a consequence of the committed and motivated few, however recent policy (HM Government, 2011) and commissioning developments (JCPMH, 2008; JCPMH, 2012) suggest that a wider interest has been taken in moving the agenda forward nationally. This may lead to

improvements, practically in the hours of service and, if the right interventions are offered, to facilitate staff moving to a more understanding and knowledgeable approach. Consistent provision of LMHC in all hospitals over 24 hours may lead to more consistent meeting of service users' needs.

### ***7.3.2 Improving the experience of mental health service users in the emergency department and the wider general hospital***

Lindgren et al (2004) also made the connection between good experiences and staff believing service users' feelings and showing understanding. Again, as with the study by Palmer et al (2007), there were themes represented which were in common with those of the current study, suggesting that important aspects of caring for those who self-harm are also important to those in a broader range of psychological distress in the general hospital including the ED and are not just unique to those who have self-harmed. Therefore it is vital that the health care professionals are able to communicate understanding, not necessarily agreement, of individual experiences and to understand the expectations that service users have. These are key elements of the person-centred approach and important aspects of the conceptual map presented later (figure 7.1 and section 7.4), particularly when it comes to the interventions of the LMHS through assessment and intervention. Service users in Lindgren et al's (2004) study identified with the importance of a knowledge base in the area of self-harm and service users in the current study identified the need for staff to have appropriate clinical knowledge to make effective assessments.

Bryant and Beckett (2006), in interviewing 24 service users about the experience in the ED following self-harm, found that being accompanied improved the overall experience. The current study identified that how carers are treated was important, they needed to be taken seriously and listened to. Bryant and Beckett also found that the ED staff struggled to offer a positive approach to those who self-harm, which in turn discouraged attendance leading to greater risk of further self-harm and possibly even death. Having found the issue of potential harm striking in the discourse of the service users interviewed for this study it is interesting to see it feature in studies with this group of service users who self-harm. In the ED waiting times, being kept informed of what is happening and privacy were themes from the Bryant & Beckett (2006) study. There were a number of similarities related to communication, namely the importance of being kept informed and a considerate approach were comparable themes.

In terms of the core category of negotiating and navigating the system, the inconsistency and inadequacy of action plans and outcomes was identified and it was noted that service users lacked the knowledge to know what was available. This again is a commentary which places the impetus on the service user to know, which, it is argued here, is entirely unreasonable in the context of engagement with services as a service user. The thematic analysis of the data obtained by Bryant and Beckett (2006) took its themes from those first identified in a study of 45 service users' experiences of the

ED (Horrocks et al 2005). In Horrock et al's study it was striking that the service users at times used identical words to describe their experience as those used by service users in the current study. For example one service user talked about wanting to get to the "root of the problem" (Horrocks et al 2005 pp 20), as Caroline does in the current study.

*"The strength was, for the last one in particular was the fact that I was spoken to or seemed as if I was being spoken to, to try and find out a root of the problem,"*

(Caroline)

However, with this different data set there are some interesting comparisons. There was far less emphasis in the findings of the importance placed within the current data of the need to talk. In fact, the Horrocks et al (2005) data suggested that the service users may be resistant or not be receptive to talking; this did not resonate with the findings of the current study.

Horrocks et al (2005) have identified an aspect not evident in my own analysis of the data, namely that the service users in their study spoke about concerns in returning to the situation that may have led to the self-harm. This thread was not evident within my own data, however the issue of potential further harm was evident, but only when the interaction with the LMHS was not possible or left an unresolved issue and this was not connected directly to a return to their personal situation and circumstances in service user discourses.



### ***7.3.3 Links between the NICE (2004) self-harm guidelines and the experience of liaison mental health care***

Comparing the findings of the current study to the key qualitative data set from the NICE *Guidelines on the Management of Self-harm* (NICE 2004), there were some similarities and these included the identification of the ED as the least helpful place to seek support, resonating with the category of 'friends before the ED' and 'not wanting to use the LMHS again' in the current study. However service users in the current study also had positive experiences which therefore helped to identify what was effective for service users.

The NICE data was specific to self-harm and the ED, a data set which is inherently different but also similar to the data set for this study, the data set was more confined than the current study which whilst encompassing service users who have self-harmed covered those presenting with a much more varied array of psychological distress. The experiences from NICE (2004) also focused primarily on the experience of interactions with the ED staff rather than the experience of mental health care within the ED. Service users reported wanting to avoid using the ED and in extreme cases feeling that they would rather risk dying as a consequence of their injuries than attend the ED as they found the experience isolating and humiliating (NICE 2004). The importance of being listened to and treated as an individual came through the data as having the potential to improve or lead to a satisfactory

experience in the ED. However, when service users are not listened to, they were not honest about their feelings and reasons for self-harming (NICE 2004) and therefore it can be extrapolated that any psychosocial assessment undertaken in that context will not form an accurate identification of the issues and could not therefore lead to appropriate care and treatment in the long term. Aspects of the environment including the need for privacy and calm without being isolated were evident in the NICE data and the current findings, clearly service users were affected by where they waited and who was with them, they feared isolation in the ED and long waits, there was a perception that they were left to wait for unreasonably long periods (NICE, 2004). Information giving and the concept of being kept informed was important to those who have self-harmed as it is in the current data.

#### ***7.3.4 Learning from service user experiences of crisis care; implications for liaison mental health care***

Lyons et al (2009) found that service users defined their crisis in terms of words such as “*fear*”, “*desperation*” and “*distress*” (Lyons et al, 2009 pp428) and also identified that they did not know where to turn, all of these experiences and emotions resonate with the findings of the current study. Lyons et al also identified the risk of harm as evident in the discourse of service users in crisis. They included a service user quote to that effect,

*“I never reached the state of actually making a suicide attempt but I have experienced feelings of absolute hopelessness and despair”*

(Lyons et al, 2009 pp429)

Also resonating with the narrative of the service users in the current study,

*“the wrist slashing and hospital admission might have been avoided if I had been offered CPN level counselling at home immediately after the paracetamol overdose.”*

(Lyons et al, 2009 pp429)

This service user was referring to themes for the current study such as the potential and actual harm, the prevention if things had gone right and the importance of follow-up. In considering service improvements service users in Lyons et al (2009) study wanted improvements to availability of staff and services in the ED. They also identified the need for better sign posting of service users about where, when and how to get help. LMHS should be able to offer these services.

Another aspect identified in the themes of the Lyons et al study (2009) was the challenges of navigating through the issues of access to services, particularly for those who were having their first experience of a mental health crisis. Service users in their study, used the word “rules” to articulate their experience of the gatekeeping and access criteria for services. When they failed in their attempts to access services in a timely way, service users felt that staff lacked empathy and had not acknowledged their distress. Lyons et al (2009) reach the conclusion that, in the context of home treatment and in-patient care, gatekeeping thresholds were too stringent and that services

should be available for service users as the crisis develops. They recommended that self-referral should be considered. This finding resonates with the recommendation from the Patient Experience *Guidelines for Adult Mental Health* that Crisis Services should be available to all (NICE 2011).

However, given that this access for all to crisis services is not currently available, it is possible that the ED presents a means of self-referral where the threshold is lower and therefore makes the service more accessible when psychological distress develops. Lyons et al (2009) do not identify the ED as an option for meeting support needs of those service users who identified that they were in crisis but do not meet professional criteria, despite that fact that some service users interviewed had finally accessed services through that route. This may be because of the style of provision within the part of the UK where the study was undertaken or the negative experience that service users reported who had used the ED to access services.

### ***7.3.5 Service users of liaison mental health care provide new perspectives on the health care experience***

In considering the available literature from service users who self-harm, or use crisis services, it is possible to identify that the current findings resonated with these findings. However, no single study reflects the overall findings presented here. Uniquely this current data set was not limited to self-harm, furthermore it explored the experiences of interactions, not just with the general hospital, or with mental health service, but both, as they existed in

the form of a general hospital LMHS. As a consequence of considering the current data, before embarking on the literature review of service users experiences, or because of the unique nature of the participants, a new concept of the need to navigate and negotiate the journey through LMHC has emerged. In seeking to articulate and explore these phenomena further a conceptual map of the journey and the challenges it presents is presented.

#### **7.4 A conceptual map of the journey of a service user through liaison mental health care: Negotiating and navigating the system**

This section of the discussion is presented with reference to a conceptual map (Figure 7.1 The Journey of a Service User Through Liaison Mental Health Care (LMHC): Negotiating and navigating the system). The conceptual map represents the experiences of service users as a journey along a road. The journey is delineated by four sets of traffic lights because it is argued that there are four distinct phases to the journey through LMHC, pre-contact, arrival, assessment by the LMHS and outcomes of the LMHS.

During each phase of the journey the service user can move forward from an initial starting point of hopelessness and potential harm through person-centred care and onwards towards greater hope for recovery. However, as with every journey we undertake, there are potential enablers and potential barriers. The enablers to an effective journey through LMHC are identified in green and represent experiences that allow the service user to progress and continue to negotiate through the system. Should the service user encounter

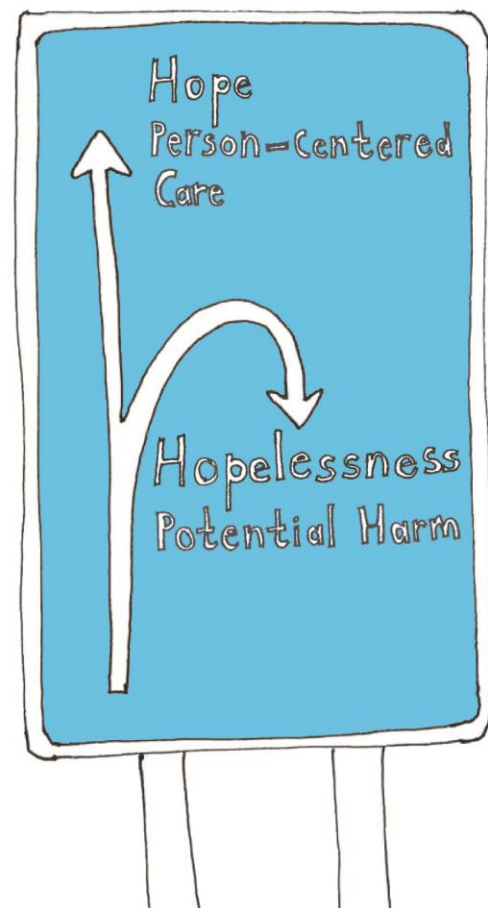
an orange light their journey is slowed or negatively affected, for example by not knowing where to go to access help.





# THE JOURNEY OF A SERVICE USER THROUGH LIAISON MENTAL HEALTH CARE (LMHC)

Negotiating and Navigating the System



## Key:

**Traffic Light** A key junction in the service user journey

**RED** Experiences that prevent the service user progressing

**AMBER** Experiences that delay the service user during their journey

**GREEN** Experiences that move the service user on to the next junction



Figure 7.1: The Journey of a Service User Through Liaison Mental Health Care (LMHC): Negotiating and navigating the system

Sarah Eales 2013





As identified within the findings the service users must negotiate and navigate first into the care of a LMHS. In order to set off on the journey the service user and/ or those around them must recognise that there is a need for help and furthermore be able to identify how to access that help.

From the conceptual map, a red traffic light, if encountered, indicates when a service user will be prevented from continuing their journey through LHMC, an experience of not receiving person-centred care and therefore, not able to move on towards hope. For example if the service user attends out of LMHS hours there may be no-one available to appropriately assess them. An encounter with a red traffic light stops the journey along the road to hope and sends the service user out of the LMHS, possibly even before they have truly navigated into LMHC. A red light sends the service user down another road where their psychological distress is not recognised and not addressed, as a result they fall away from the LMHS onto another road which leads to continued hopelessness and also increased risk of potential harm.

By successfully negotiating and navigating the system, through a series of obstacles, and associated green lights, the service user arrives at the end of the journey through the LMHS. This is by no means the end of the road for most service users, their journey to recovery has only just begun, but they now have the hope to continue. LMHS offer one route that service users' access that could, if they are able to navigate through effectively, improve their psychological distress and thus lead to a positive outcome.

The findings of this study illustrated that service users may make a number of attempts to journey through LMHC before they navigate to a successful outcome, thus finding hope and reaching a point where recovery is possible. Recovery does not necessarily mean a return to the status prior to their psychological distress. As the literature on recovery identifies, this can mean a variety of things, including a process or period of recovery, achievement of a personally acceptable quality of life or a return to a state of wellness (NIMHE 2004). Within the study there was evidence (for example from Mark) of service users who make several attempts to navigate the system before they are able to find an outcome which moves them into the next stage of recovery which, for Mark, is a period of specialist in-patient care. There is also evidence from service users, such as Olivia, who use the service as part of their recovery strategy on an on-going basis.

The development of the conceptual map was influenced by the work of Entwistle et al (2012) in so much as the language used in the map attempts to situate the reader as a service user travelling the journey and also attempts to highlight the positive potential to complete the journey at the top of the map and using the green lights.

There are a number of key areas of theory which are drawn upon which lie outside of the remit of the literature review, namely the literature on hope and person-centred care. It will be argued that these two concepts are important aspects of the service user journey.

The following sections discuss, firstly, the direction of travel from hopelessness and potential harm through person-centred care to hope. Each of the four phases of the journey is then discussed in turn.

#### ***7.4.1 Direction of travel – Person-centred care as an enabling factor to effective health care***

Service users have described a sense of hopelessness prior to their contact with LMHS and this was a core feeling that prompted the service user or their carers to attempt to get help for their psychological distress. Strikingly, the service users spoke directly or indirectly of the potential or actual harm that occurred if they did not receive the help that they needed. The conceptual map shows that as the service user travels the route of entering and accessing LMHC they can, for various reasons and at various points, fall away from the LMHS and this places them at further risk of harm.

As service users travel further into and along their journey through LMHC the assessment, intervention and outcomes, or action plan needs to make sense to the service user as an individual. It is argued that LMHC does not work if the service user is not able to understand the interventions on a personal level and this fits with the concept of person-centred care (Gerteis et al, 1993; McCormack & McCance, 2006; DH, 2011a). Person-centred care has

developed in a number of arenas and has been adopted in a number of forms most effectively in older adult healthcare (McCormack et al, 2012).

Within the culture of the ED and in the wider general hospital it is not unusual for service users to experience depersonalisation, where they are recognised by their presenting problem or a previous presenting problem. An example was Nadia, who had been a substance user in the past and believed this affected decisions made about her care and treatment, for example with prescription of painkillers. In direct contrast, service users with psychological distress are entering the system seeking someone to accept their personhood, current distress and situation. Service users required someone to help them make sense of their distress, and provide a safety net within which they could begin their process of recovery. The experience needed to be personalised and at every level make sense to the individual service user and their current situation.

Person-centred care and patient-centred care are two concepts that have developed in health care over the past decade. To some extent they have developed independently in the nursing and medical literature (Kitson et al, 2013). Patient-centred care is more frequently used in the medical literature (Brown et al, 1986) and internationally, whereas person-centred care is more frequently adopted in the nursing literature and has developed in the UK, primarily through the work of Brendan McCormack and Tanya McCance (McCormack, 2003; McCormack & McCance, 2006) working in the field of older adult nursing. The term person-centred care was also the term adopted

in the NICE guidelines on Patient Experience in both acute physical and mental health care settings (NICE, 2011; NICE, 2012).

In line with the author's profession and also because nurses constitute the majority profession within multi-disciplinary LMHS, the term person-centred care has been used in this discussion; there was also evidence of its increasing adoption as a term within the medical literature (Macleod & McPherson, 2007; Mezzich et al, 2011). The literature which uses both the terms person-centred and patient-centred has been incorporated into the discussion. Kitson et al (2013) offer a review of the development of both patient-centred and person-centred care concepts and identify three core themes that pervade the key literature, these are, patient participation and involvement, the relationship between the patient and the health professional and the context where care is delivered.

Hughes et al (2008) in reviewing five iterations of centredness (i.e. person, patient, family, client and relationship) identified that the emphasis tends to differ dependent on the context and that all iterations of centredness had similar themes of which there were ten, including respect, autonomy, expert lay knowledge and therapeutic alliance) It is argued in this conceptual map that in order to have a successful journey into and through LMHC the service users have identified with many of the principles of person-centred care. Given that the conceptual map is focused upon the individual journey and the nursing background of the author this is perhaps why the person-centred iteration has been adopted as one which places the service user (person) as

the emphasis for the adopted centred-ness. As will be seen in section 7.5 when the focus changes to the needs of the staff caring for the service user the relationship centred model has more resonance.

#### *7.4.1.1 Applying a person-centred care model to liaison mental health care*

The framework refined by McCormack and McCance (2010) identified four constructs, which are “*prerequisites*”, “*the care environment*”, “*person-centred processes*” and “*outcomes*”. The framework is reproduced (with permission) in figure 7.2. “*Prerequisites*” included the competence and engagement of the staff with the area of nursing care, in this case study mental health care in the general hospital and also awareness of their own values and beliefs, how they impact upon care giving and also how the ‘self’ impacts upon the nurse’s ability to engage in person-centred care. The prerequisites have been considered in applying the service user experience to the literature on self-harm service user experience (section 7.3.1).



**Figure 7.2: 'Person-centred nursing framework'. (McCormack & McCance, 2010).**

The second construct is the “*care environment*”. This referred to the organisational structures and commitments that enable or prevent delivery of person-centred care. In the context of the current study and the conceptual map, if a LMHS is not commissioned or available for part of each day or at



weekends an organisational barrier would instantly be created to the service user reaching the end, or even entering into their journey through LMHC. Service users in the current study had experience of being left waiting during the night without being offered mental health care for their psychological distress and after waiting for a number of hours they left the ED without treatment leading in two cases to significant actual harm, for one service user (Evan) in the form of an overdose, and in one case the collapse of the persons employment and relationship (Mark) which he subsequently identified with his untreated mental health issue.

Mark reflected that had he been seen and assessed at his first presentation he may have had a different journey in his personal life and the ensuing breakdowns could have been prevented. The construct “care environment” does not specially incorporate the basic practicalities of the environment such as a private and quiet place to wait, as identified in this study. Therefore from the findings of this study it is argued that at an organisational level the practical environment needs to be considered. For example, if the hospital is rebuilt, to what extent if at all are the needs of those with psychological distress or mental health issues considered in the design and build of the physical environment.

Figure 7.2 (above) identifies the activities undertaken by the nurse (and arguably any healthcare professional) that constitute the “*person-centred processes*”. When the psychological distress presentation includes actual harm providing for physical needs is an important aspect of the overall

service user journey, this is also the case in the context of being seen on an in-patient ward where the primary reason for admission will be a physical care need. It is possible for the psychological distress to create a barrier to meeting the physical care needs of the service user. For example, Rugina explains that ward staff avoided her because she was crying a lot, the main intervention of the LMH professional was to explain why she was crying which helped the staff to engage more with her and meet her physical needs. Fundamental aspects such as engagement are pre-requisites to positive experiences such as having the opportunity and time to talk. McCormack and McCance (2006; 2010) linked the “sympathetic presence” aspect of person-centred care to the emotional intelligence of the nurse (McQueen, 2004). Emotional intelligence is defined as the person’s (the nurse’s) ability to regulate their own emotions and to offer an empathic response to the emotions of others (the service user). In Rugina’s case the LMHS intervened to support the empathic response.

The final construct is the “*person-centred outcomes*”. In the conceptual map the end of the journey through LMHC is also called outcomes. One aspect of the conceptual map which does not appear to clearly fit into the identified outcomes of the framework is the greater understanding of the psychological distress which is evident in a positive outcome for LMHC. As identified in the findings, making greater sense of the situation and emotions is a very important aspect of a positive experience of LMHC; the insights can be at different levels and needs to build upon or slot into the information and understanding that the service user already has of the situation (Figure 6.5).

Where McCormack and McCance (2006) have identified the outcome of “a feeling of well-being” this was not identified within the current study, however the importance of moving from the sense of hopelessness experienced prior to embarking on the journey to achieving a sense hope as the journey progresses has some similarities with a sense of well-being in so much as both indicate an improvement and a positive effect on the health of the service user. In the case of the current findings the effect would be on the mental health of the individual. The fit of the conceptual framework for person-centred care appears to be a good one. This framework appears only to have been applied within older adult care and not specifically in the adult mental health care field. It would be valuable to consider if its practical application in a multi-disciplinary LMHC team could enhance aspects of the service user experience. The practical application of person-centred care to LMHC is developed in the recommendations (Chapter 8).

#### ***7.4.2 Pre-Contact – Recognising the need to seek help for psychological distress***

Before contact with the hospital or the LMHS those people who have no prior experience of mental health service provision the expectations are, what we as professionals might see as quite stereotyped or old fashioned, and include receiving medication (Brynn, Caroline, Donald and Olivia), admission to psychiatric hospital (Ahmed, Mark and Leon) and also that the person they see will be a doctor, i.e. a psychiatrist (Brynn, Gill, and Olivia). There was for some a clear aspect of trust, of placing themselves into the hands of someone who would make the right decision (Kevin and Holly) . Some of the

stereotypical expectations emanated from those who had no prior experience of mental health services and their expectations were arrived at via perhaps a media portrayal of mental illness and hospital settings. Other service users' expectations were simply to be given the opportunity to talk to someone, primarily to make sense of the psychological distress (Mark, Nadia, Janice and Fouad). Some service users did not know what to expect (Holly and Evan). In LMHC service users often reported that their expectations were exceeded or that their needs were met but not in the expected way, for example those who expected to see a psychiatrist were equally likely to see a nurse or a social worker who would take them through the LMHC journey and help them navigate to an effective outcome .

Not all service users are new to mental health services, yet they also make use of the ED and the LMHS. Recent clinical guidelines from NICE on Patient Experience in Adult Mental Health Services (NICE, 2011) recommended that service users require comprehensive access to care over a 24 hour period irrespective of their diagnosis and suggested that this should be via Home Treatment and Crisis services. In preparation for such events they set out guidance on the development of crisis plans for service users. A feature of the Liaison Mental Health Care course<sup>11</sup> which the author runs at City University, London is the risk assessment teaching session during which the issue of crisis plans is considered and to date one of the key criticisms levelled by the LMH professionals attending the module is that they are regularly confronted with crisis plans which simply direct the service

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<sup>11</sup> [http://www.city.ac.uk/\\_data/assets/pdf\\_file/0019/162109/NM3036-Liaison-MH-flyer-Apr-13.pdf](http://www.city.ac.uk/_data/assets/pdf_file/0019/162109/NM3036-Liaison-MH-flyer-Apr-13.pdf)  
[accessed 20-06-13]

user to the ED at a point of crisis, most especially if the crisis occurs out of hours. The NICE guidance (2011) recognised that at present Home Treatment Teams and Crisis Teams have referral criteria that limit the diagnosis of the service users who they will assess and treat. Furthermore the NICE Guidelines (2011) recommended telephone helpline services be implemented in all areas for those with mental health needs and that all GPs are aware of these. If the NICE guidelines were met across the UK this would offer alternatives to presentation at the ED for many with psychological distress and mental health crisis, however these data show that whilst services may be available service users must know when and how to access them and that whilst we as professionals can possibly maintain an up to date knowledge and understanding of service provision service users do not know where to go and the ED represents the “front door” to healthcare (Fernandes, 2011).

#### *7.4.2.1 Is it inappropriate to treat psychological distress in the emergency department?*

It is clear from these service user findings and the wider literature (NICE, 2004) that service users do not always know where, when and how to obtain help at times of psychological distress. This leads to the exasperation of the ED staff who perceive people to be inappropriately utilising the ED to obtain help for psychological distress. This appears to be related to two distinct issues, firstly that ED professionals do not consider psychological distress to be an appropriate presentation for the ED. Secondly the service users themselves are unclear about how to access help for their psychological

distress. This is layered with a stigma related to mental health issues. Guidance had recently been produced (College of Emergency Medicine (CEM), 2013) and work has been undertaken in relation to those who self-harm (Palmer et al, 2007) to attempt to address the negative perception of those with psychological issues attending the ED, however this approach continues to pervade the ED and also across the wider general hospital setting (Conlon & O'Tuathail, 2012; Saunders et al 2012). At the level of the general hospital the current government strategies directly address the relationship between physical and mental health (HM Government, 2011) and commissioning guidance for urgent and emergency care from the Royal College of GPs (Fernandes, 2011) indicated that as evidenced by these data service users will present to the ED and commissioning should more adequately reflect this situation. This is an important point and evidenced by the findings the ED and the general hospital need to operate in such a way as to accommodate psychological distress. The LMHS is the service available to support general staff in responding to the psychological distress of hospital patients and needs to be responsive to that need, being commissioned in such a way that there is capacity to respond, this will mean robust LMHS that are available and do not lead to long response times which can lead to service users leaving the hospital without their psychological distress being addressed, which it is argued can lead to potential harm to the individual and the continuation of hopelessness.

Secondly the informal link some service users had with LMHC created an unacknowledged safety net. The safety net was an important concept that

ran through the whole experience of the LMHS. Some service users who were interviewed knew about the LMHS and had an open invitation to drop by or call whenever they needed to talk, this served to help maintain them in the community and the open access to the ED and a 24hr LMHS offers this access and availability however there is much difference of opinion in the professional literature as to whether this is appropriate. Furthermore it could be argued that this informal safety net of open access to the ED for mental health service users can foster a dependence that current mental health policy seeks to undermine (Shepherd et al, 2008). Having worked in the area of severe and enduring mental illness for many years these informal and often unrecognised relationships are vital to the well-being of some service users, yet given the difficulties presented for service users in the ED it would seem appropriate and in-line with current guidance (NICE, 2011) to ensure that mental health service users have crisis plans that do not encourage attendance at the ED but foster more appropriate safety nets for those already in contact with services.

A flawed safety net was evident with the recommendations for psychological assessment of self-harm not being met effectively by the introduction of LMHS (Bennewith et al, 2004). Bennewith et al's study of self-harm presentations across the UK found that the implementation of LMHS within the ED did not necessarily improve the number of psychosocial assessments undertaken, the study was unable to identify whether this was due to the hours of LMHS provision, staff availability to undertake the assessment, or the lack of referral to the LMHS following treatment for the physical

consequences of the self-harm. LMHS needs to be available to offer psychosocial assessment for those who have self-harmed and also have a role in developing the awareness and skills of the ED staff to identify and refer those who would benefit from a LMHC assessment, not just in the context of self-harm but in relation to all psychological distress. The initial findings from the economic evaluations of the benefit of the LMHS (Parsonage et al, 2012) recommended the need for 24 hour services to ensure that there should be provision when needed by the service user. The data from the service users in this study identified that a service user in psychological distress can remain in the pre-contact phase despite having already attended the ED because there is no service available.

#### *7.4.2.2 Recognising the need to support psychological distress in the emergency department*

The theoretical perspective presented here argues that the service user experience of LMHC must incorporate the pre-contact phase of psychological distress that the service user experiences. Recognition is the term chosen to attempt to accommodate the challenges for the service user in the phase of pre-contact. For service users who are experiencing psychological distress for the first time or have yet to find a service which meets their needs they do not themselves know who to contact and where to go, nor do they necessarily wish to enter into seeking help for their mental health issues, with the stigma that this might entail. Furthermore for service users who have an acknowledged mental health issue who are in crisis in the community the message they may have received from mental health



services is when in crisis go to the ED for help. Recognising the build-up to the crisis and the resulting pre-contact phase was not evident as a construct in the frameworks that articulate service user experiences of health care (Donabedian, 1980; Gerteis et al, 1993; Nolan et al, 2004; McCormack & McCance, 2006 DH, 2011a; Entwistle et al, 2012). Incorporating this aspect of the conceptual map is vital to engaging the service user effectively with LMHC.

There is another pragmatic aspect to recognition, in so far as at present whatever the desires for the future of service provision in the ED, service users will present with mental health issues and the professional staff within the ED both LMH and acute staff must recognise that these presentations are occurring and that the service user is not purposefully seeking to undermine the role of the ED, but simply does not at this point know where else to go. As such, they are attempting to negotiate the help they need via the “front door” of healthcare (Fernandes, 2011). As professionals we see the GP as that front door; however the GP does not represent a 24-hour option and quite simply the ED does. This has led to a current crisis in emergency department (CEM, 2013) with increasing unsustainable demand.

Recognition is also about the barriers presented within the in-patient setting, evidence suggests (HM Government, 2011) that much of the psychological need within the general hospital in-patient setting is going unidentified and service users experience within this study attests to this. LMHS will have a

significant role in improving the identification and raising awareness of the importance of supporting the psychological and mental health needs of those in hospital for physical healthcare, the specific models for this are discussed further in the recommendations chapter (Chapter 8).

Sending a message that communicates a lack of interest or collaboration to service users has been identified in the literature on the experiences of those who present to the ED with self-harm (Palmer et al, 2007). Strikingly, this then leads to service users not being honest about their psychological distress. This literature and the negative experiences of some of the service users led to the inclusion of the “I never want to use the service again circle in the pre-contact phase of the conceptual map. There are service users who have used this phrase to communicate how desperate and hopeless they felt when they came into contact with the service, their use of the term is encompassed within the overall theme of hopelessness through to hope. However there are others, from the literature and the findings of the current study, who use the phrase to show that they would avoid the service at all costs, the concern here is that this may be to the serious detriment of their mental and physical health as they may be at risk of actual harm.

#### *7.4.2.3 Recognising psychological distress is a prerequisite to effective liaison mental health care*

Returning to the person-centred care framework, which it has already been argued has a strong fit with the conceptual map presented here, the organisational issues of staff perceptions of the appropriateness of mental

health issues as care needs within the general hospital setting is addressed through the construct of the “pre-requisites”. This construct can be related to the values and beliefs of the nurse and in this study the wider healthcare team and also to the knowledge of the self and its impact on delivering care. In seeking to meet the needs of those who present with a primary psychological issue or for whom psychological distress impacts upon physical healthcare service users need to encounter positive healthcare professionals who acknowledge the appropriateness of their needs. The application of the person-centred care framework (McCormack & McCance, 2006; McCormack & McCance, 2010) could be a means to facilitate consideration of the impact the healthcare professionals attitudes as presented to the service user impact upon outcomes. Furthermore this construct encompasses the competence of the professional in terms of knowledge and skills to care for their patients, again this was identified as important by the service users interviewed in this study. In the pre-contact phase it is important that the professional is able to recognise the need for intervention by the LMHC team and to make the appropriate referral.

#### ***7.4.3 Arrival – Finding assistance to obtain help***

When the service user presents their psychological distress to healthcare professionals either in the ED or as an in-patient the primary enabler is that the distress is recognised and that steps are taken to seek assistance for the service user through a referral to the LMHS. Service users need to feel that they are understood, as do their carers and friends. The conceptual map identifies that the message conveyed needs to be one of collaboration and

co-operation and by acknowledging the need for assistance the service user has a sense of being understood. Furthermore this sense of collaboration is enhanced by ensuring that the service users receive the message that they are going to be seen and that they have been prioritised. This involves ensuring that the service user and their carers are kept informed of the process and any waiting or delay is explained. Whilst the service user is waiting they need to be kept comfortable, in the ED this means waiting in an area that the service user considers comfortable, for most this is a quiet and private space, but not for all. In the in-patient setting this is about the ability of the general hospital staff to offer some support until the LMHS arrives, in order to prevent the service user's psychological distress from deteriorating.

Arrival is also, in part, about the nuances of attitudes that staff present. The ED or LMHC staff may have a sense a service or individual has not done their job adequately if a person in psychological distress presents at the ED. This is particularly the case if the service user is well-known to mental health services or has presented at the ED before, especially if that presentation was recent or attendance is frequent. The staff may perceive that the GP has not managed the service user through referral to Improving Access to Psychological Therapies (IAPT) mental health services (DH, 2012), consequently the conclusion is reached that ED attendance could have been avoided. Very recent reports by the Foundation Trust Network (FTN) (FTN, 2013; FTN, 2012) and endorsed by the College of Emergency Medicine (CEM, 2013) made exactly this case and have received much media attention directed at the changes to GP provision in recent years. The

allegation is that out of hours care for mental health needs is rarely available; the reports do not acknowledge the role of services such as mental health and Home Treatment Teams.

The 'fault', for example of needing to attend the ED, may be attributed to the service user. The conclusion may be quickly reached, with little discussion, that the service user is not taking prescribed medication properly, or that this is a self-inflicted act of self-harm (NICE, 2004; Mackay & Barrowclough, 2005), this does not represent a person-centred approach. As a health care professional the notion of the GP as the gatekeeper is perhaps clear. However, the experiences of not knowing where to go and not knowing what might happen re-emphasised the notion that for service users the differentiation and delineation of service provision was not clear and our professional expectation that the service user can effectively negotiate their own journey through services is an unrealistic one. Thus the presentation of psychological distress at the ED or in the context of an admission for a physical health issue is taken out of the context, the pre-contact and build-up is ignored and seen as irrelevant when we are at the stage of accepting the service user into the service or considering the referral to the LMHS. The self-harm literature (NICE, 2004) suggests that these experiences will feed into whether the service user would consider accessing the service again or not.

#### *7.4.3.1 Not collaborating to offer help has negative consequences for service users*

Current (2013) commissioning guidance for Clinical Commissioning Groups (CCGs) regarding urgent and emergency care indicates that the current situation resonates with the experiences of the service users interviewed for this study.

*“It is no wonder that the public, patients and indeed health professionals themselves are confused about what to do and who to call or where to go– despite multiple attempts to clarify in different parts of the country with “choose well” campaigns.”*

(Fernandes, 2011)

The impact of these attitudes and uncertainties negates positive and supportive reinforcement that these findings identified as being crucial at this point in the service user’s journey, the point of arrival and the need for LMHC. This can manifest to the service user because they are not prioritised and have to wait for extended periods. When service users perceive that they are not being taken seriously they may take a number of actions, including simply walking away, ‘acting out’ to make their distress more overt, or not disclosing the nature or extent of their psychological distress; all these behaviours were reported by the service users interviewed for this study.

One service user takes a further overdose as a means to prove that they are not well and should receive care, although the care they believe they require is physical not psychological.

*“I did it here to prove a point [took another overdose], to say I wasn't feeling well. I was going home, I couldn't walk more than a few chairs. I have to sit down, something is definitely wrong , this is a man who can walk and walk and walk, so I come back and ask them to let me see a doctor and they said sit down. I waited twelve midnight to nine am, other people coming in and seeing a doctor. I took them to get the doctor to see me. Then they say I'm not sick, it's my body I know how I feel. That time I wasn't thinking about it like I was before. I wanted to show the doctor things can happen and you don't know.”*

(Evan)

This service user has clearly been seen in the general hospital for a physical health issue and has moved into the mental health services through the means that he used to attempt to have his physical distress acknowledged and investigated further. His first encounter with LMHS, where he was not prioritised and left without being seen, does not suggest that his attempts to communicate his level of psychological distress were unsuccessful, rather that he was being ignored, seen as a low priority over other emergencies. This service user (Evan) believed this elaborating or escalation approach would work, what he saw and felt as a result of being ignored suggested to him that this escalation tactic was the most appropriate means of effectively communicating his distress. It was possibly the professional's lack of

collaboration, or assessment of his level of distress, which led him to believe this was what was required of him to obtain the attention he expected to receive. In his discourse Evan is clear that he believed he had articulated that his physical health was not improving and that he was not happy with being discharged. From a LMHC perspective this presentation would appear to have warranted an assessment yet it appears that an assessment and potential intervention did not take place prior to the overdose. This is perhaps an example of just the type of presentation (prior to the overdose), that is complex and unclear in its origins. From a cost saving point of view, Evans first presentation warrants intervention by the LMHS (Parsonage et al, 2012). Navigation into the system only occurred once the service user took matters into his own hands and was not professionally facilitated until potential harm had become actual harm.

Other barriers are created when service users ask to see a liaison nurse or a psychiatrist however this was either not communicated to the LMHS or resources were not available to offer a service, including presentation out of core hours (8am to 9pm at the time of the data collection). The provision of a 24-hour LMHS is now the recommended standard in the most up to date commissioning and service evaluations as the policy and research review identifies (NHS Confederation, 2011; Parsonage & Fossey, 2011; Parsonage et al 2012; JCPMH, 2012). The provision of a 24-hour service enables access; however, the ability of general healthcare staff to recognise the need for LMHC intervention and their awareness of the possible benefits is the second aspect of ensuring that service users' needs are effectively met. The



benefits have been identified in the literature review of the structure process and outcome of LMHC (Chapter 3).

There is a clearly identified need from the literature review and the findings of this study for LMHS to work with all general hospital staff to continue to improve the knowledge base and skills to identify mental health needs within the general hospital setting across both in-patient and emergency services. Therefore it can be argued that Caplan's model (Caplan, 1970) which incorporates the educational aspects of the role of LMHS is as valid today as it was at inception in 1970. It is argued here that the value of education to enable general hospital staff to provide a person-centred approach that does not place the impetus upon the service user to be the assessor of appropriate care is necessary. Service users should be able to simply present with their psychological distress and be sign posted effectively within the general hospital services to mental health care provision via the LMHS. It is argued that is a reasonable expectation of general hospital provision. Current government policy would indicate that this is a recognised need and a goal for healthcare in the 21<sup>st</sup> Century (HM Government, 2011; NICE, 2011). There are however organisational barriers to attaining this goal.

Lyons et al (2009) identified that there was a clash of culture and expectation in so much as the inclusion or referral criteria are predefined and "linked to procurement and contracting processes rather than individual need" (Lyons et al, 2009 pp427-8). In their review of service users' experience of crisis intervention services this led to crises escalating in order for the service user

to be accepted into care and treatment, rather than being able to respond when the crisis was lesser but when the service user and their carers know it will develop and deteriorate if not addressed. This approach was evident in some of the service users' experiences of the ED and LMHS, they were not prioritised or their problems were not identified because their psychological distress was not evident or prioritised. This may explain why service users chose to escalate their own situation to 'better' articulate their needs in a way that services would acknowledge, in this study examples include the young lady who 'acted out' to get herself moved to a quieter place and the man who took the overdose to get his physical health problem reviewed.

By their own admission, service users' presentations when in distress can be very threatening towards staff (Ahmed) and the data in this study suggested they do not necessarily experience being taken seriously. When service users are taken seriously this validates their experience, sending the message that 'yes you are unwell', and they feel believed. Consequently this suggests underlying issues regarding whether the service user is deserving of the time and resources both of the general hospital and the LMHS. In exploring the literature on self-harm this idea of being undeserving and the related issue of low self-esteem has already been introduced. Service users in the study explained that they expecting to be "shunted out of A&E" (ED) to mental health services (Harry) or that mental health provision would not be offered (Evan, Harry, Kevin, and Fouad) but did not have a clear understanding of where else to go.

Current commissioning guidance argues that,

*ED-UCCs [urgent care centres] need to be able to deliver the most efficient and effective care for children, frail and older people, mental health patients, substance abusers and the homeless. These groups by virtue of their physical, emotional and social isolation do not access the “right” services so the services need to be right for them at the point of access – which frequently is an emergency department and out of hours.*

(Fernandes, 2011)

#### *7.4.3.2 Sign-posting and supporting those in psychological distress*

The findings of this study support the argument that emphasis needs to move from expecting those who present with psychological distress, within acute care, to know where to go and what services within primary care should be appropriate for them. Fernandes (2011) concurs, that the ED is frequently the access route and that service users should not be penalised for presenting there. There is emphasis on accepting the presentation of those with mental health needs at the ED and also that those with unmet mental health needs may come to the attention of services whilst in-patients in the acute hospital setting. Fernandes (2011) recommended that stronger more robust LMHS are required to begin the process of appropriate assessment and sign posting rather than to stigmatise these presentations, as did Parsonage et al (2012). Furthermore it is argued here that there is

another key element to the role of the LMHS, when it is fully developed, in building capacity within the acute hospital workforce to identify unmet mental health needs and to ensure that once identified those service users are referred to the LMHS who will be able to offer assessment and intervention to those patients or service users.

Therefore, it is argued that the general hospital, including the ED, must accept that mental health is part of their role. On arrival, both the environment and the approach of staff should be able to accommodate the needs of those who are psychologically distressed. The key messages that impact upon the service user experience and whether they will wish to co-operate with services, are those that show acknowledgement of distress.

Firstly, staff need to communicate that they understand the service users issue and the service user needs to feel that they are being prioritised and kept informed. Where the service user waits and the facilitation of support by family and carers has been shown in this study to be of significance in communicating that understanding.

#### *7.4.3.3 Realistic management of expectations helps service users*

One important aspect of communication is the need for staff, particularly nurses, to refrain from the use of the term 'in a minute'. The author was struck by the use of the term by one service user in their interview for this study and this proved an enlightening moment in terms of the clinical practice of the author and also in terms of educational approach.

*“Considering I was highly, well I had felt quite suicidal and that was why I went in and that I was sitting the waiting room on my own and after about the first hour I felt like just walking out. I didn't know where I would have gone or what I would have done, I don't think I would have gone off to hurt myself but it was just "What is the point in sitting here and waiting". and someone kept telling me "You will be seen in a minute, you will be seen in a minute", a paramedic<sup>12</sup> kept coming out to tell me "I would be seen in a minute" “*

(Patience)

The ‘nursing minute’ has, subsequent to the data collection, proved to be a very useful teaching tool in getting, particularly non mental health but also mental health nurses, both pre-registration and post-registration to consider their interpersonal communication with service users, at all levels. It has become an important teaching tool in helping health care professionals to understand the importance of keeping people informed of the situation and managing anxiety in the context of psychological distress. It appears from the service users in this study, the authors observation of her own and others practice, and the discussion with many nurses through the authors educational role that nurses have a tendency to reply to any request for assistance or reassurance with a sentence that invariable ends with *..’in a minute’* for example *“You will be seen in a minute”* as noted by Patience, a

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<sup>12</sup> The service user, Patience, refers to the person who comes to see her as a paramedic, it is most likely that the person communicating with her is an ED Nurse, as paramedics are not present in the ED over extended periods of time.

service user in the study. The use of '*in a minute*', the author believes is to show the service user or patient that they are being taken seriously. However it does not fully convey this message because, ultimately and also realistically, nothing happens in a minute and, in the context of the patient journey and the conceptual map, it negates keeping the service user honestly informed about realistic waiting times and avoids a proper explanation of any wait or confirmation of delay. When something does not then happen, in a minute, it conveys that the staff have perhaps forgotten or prioritised someone or something else over and above the service user, thus sending the message that their needs are less important. Finally, it does not convey an empathy, or understanding of the service user's situation.

In summary the nursing minute does not send a clear message of providing assistance and working collaboratively with the service user. The person using the phrase does, in the author's opinion, wish to convey exactly that message, however the receiver of the message is left with exactly the opposite impression. In attempting to explore if the issue of the nursing minute had ever been identified in discourse about nursing practice only one comment was retrieved, from an article entitled '*In a minute*' and written in 1990 by a student nurse (Morrison, 1990) who noted the lack of realism but frequent use of the phrase when she herself becomes a patient in a general hospital. Other passing personal references to the frustration the use of this phrase presents have been noted, Gerteis et al (1993).

#### *7.4.3.4 Collaboration must continue as the journey progresses*

Although the issues identified within the arrival phase of the journey are first experienced here they can re-present to the service user as they continue along their journey. As the assessment progresses the service user may see other professionals and as such they must have this sense that they are understood by each professional that they see. For those service users who are in-patients this is particularly important because the nature of LMHC is such that the service user will not always see the same LMHC professional over a number of days or weeks and the ability to maintain continuity and offer a collaborative experience is necessary despite changes of staff and environment changes. Environmental changes may mean moving within the ED from a cubical where treatment is primarily for the service user's physical needs to a more private space where a detailed assessment of psychological distress can be undertaken. Delays and waiting may occur during the assessment and outcome phases and therefore the service user needs to understand delays and be kept informed throughout the journey.

#### ***7.4.4 Assessment by the Liaison Mental Health service – creating a partnership***

Partnership has been identified as the overarching term used to summarise the assessment aspect of the journey. The opportunity and time to talk is the key to this part of the journey and builds upon the need for people the service user meets to convey that they understand the service user, however to be able to engage with the assessment the service user must feel that the

LMHC professional is the right person to see. Earlier the expectations of service users, particularly those with no previous experience of mental health care, were considered and it was identified that they may expect to see a psychiatrist. If the person they see is not a psychiatrist but is a social worker or a mental health nurse this professional may need to take time to explain their role and responsibilities within the LMHS so that the service user can understand why they are the right person to assess and support them.

Service users want to be assured that the LMH professional has the right level of clinical knowledge and skills to be able to offer them help. If one considers the essence of the therapeutic assessment as identified by the service users (Figure 6.5) it is possible to see that in incorporating aspects such as explaining why questions are being asked, including physical health needs and risk assessment and the use of standard questions the service user will begin to gain a sense of the competence of the professional undertaking the assessment. The suggestion from service users for standard questions articulates within it that over a number of interactions with mental health services the service user is monitoring the interactions and processes and looking for consistency, which they find reassuring. Within local healthcare trusts there will be standard assessment processes such as the Care Programme Approach (CPA) (DH, 2008) documentation and across mental health professionals and service provision service users should encounter standard questions such as those used in the Mental State Examination which are adopted across professional groups, often again incorporated into CPA documentation. Therefore it is not unreasonable for



service users to experience the use of standard questions. Overall the assessment has to make sense to the service user and this incorporates aspects such as going at the pace of the service user, exploring the person's history and conferring with significant others and explaining why questions are being asked will allow the service user to make sense of the experience as the assessment is progressing.

#### *7.4.4.1 Partnership includes involving the service user in decision making*

If the service user is to experience the assessment as a partnership it is vital that they feel involved in the decision making, for example that their consent is sought to involve carers and significant others in the assessment and that the rationale to consult with other professionals is explained. The professional needs to take the person through the process with them. The importance of the connection that the service user feels with the person undertaking the assessment is important and refers to the importance of the therapeutic relationship that forms. LMH assessments are short lived and most frequently single events so there is a need for the professional to be very skilled in quickly developing an alliance with the service user. What has gone before in the arrival phase will impact on whether the service user is willing to engage and open up to the assessment. As service users explained sometimes the questions may seem harsh and need to be very direct, particularly in the context of risk assessment, however service users appreciate the need for this; it is the skill of the professional to engage the service user that will ensure that they are able to understand the need for such direct questions and the willingness to answer honestly.

Gill incorporated many of the key concepts in the excerpt from her interview below, she was talking about her initial meeting with the LMH nurse where the nurse undertook a brief assessment possibly for the purposes of an initial risk assessment and also to get a sense of Gill's situation,

*“They took me into a little room and let me sit there quietly while I was waiting for the person and then she came, the nurse came and wanted to know some details about, basically, it was mostly about my suicide attempts, I think, just whether I was ser, whether I was serious about it, trying to work out whether I was just being silly or whether I was actually seriously having problems and I thought that was handled really quite well. I was a bit shocked at the time to be spoken to in the kind of way she was speaking to me. I didn't feel it very sympathetic at the time but in retrospect she did a really good job of getting the information that she needed and she got the right sort of information and that kind of thing. I mean she didn't keep me talking too long, she didn't try and make me feel any better or anything, you know, she didn't try and treat me in anyway at all, she was just getting the information, she didn't try and stick her oar in where, ultimately anything that she'd said to me was probably made me a lot worse, so I think she judged it really well. “*

(Gill)

Firstly Gill was taken somewhere private, part of the arrival aspect of the journey. Gill conveyed a sense that the initial assessment made sense to her

and she could see that the nurse was asking appropriate questions and on reflection she also sees the rationale for the approach in the context of her presentation and distress at the time.

Service users appreciate that the assessment is a balance of quickness and thoroughness but they were critical if they sensed that the professional was simply ticking boxes by asking questions and not genuinely trying to get to the essence for the person and to understand their situation. This defensive practice has been given an amber light in the conceptual map because the service user may still obtain a useful outcome but the assessment phase is less likely to give the full range of options and effective outcomes if there is a lack of partnership and engagement during the assessment. As reported in the findings and illustrated here by a quote from Caroline who is talking about her second use of the LMHS, if the professional does not have the right level of knowledge or skills then the outcomes will not match the needs of the service user,

*“I had four doctors just absolutely amazed that this man [LMH Psychiatrist] had given me such a high dose of sulpiride and (why) he had actually made this assumption, from a GP to three psychiatrists to make him thinking god you know, what was it that you said and it was my desperation at that point that I felt that nobody was helping me and I just felt really violent and for someone who was in the psychiatric field not to notice that, I feel as if that person was not being in touch with people.”*

(Caroline)

During her interview Caroline explained that on that second visit she was prescribed an anti-psychotic medication and four other doctors later could not understand why she was offered the anti-psychotic medication. On a later third visit she did find a connection and leaves with coping strategies advice and referral to counselling as her treatment and at the time of the interview reported that this later experience gave her the outcome she needed.

This service user was able to identify that the skills and knowledge of the LMH professional had not allowed him/ her to offer an appropriate treatment and she identified that this was about the ability to ask the right questions in the assessment. The service user did not go on to specify the exact skills and knowledge needed however she could articulate that it was lacking in the assessment. Other service users expressed specifically that LMH professionals needed to have in depth knowledge of a range of specific conditions and these included depression, schizophrenia and substance misuse.

Entwistle et al (2012) identified that, in developing their own conceptual map, they initially excluded service user opinion about the characteristics of staff, having been guided by previous literature such as Donabedian (1980) that service users were not in a position to judge this aspect of service provision. However they latterly included the service users' feelings and the quote from

Caroline illustrated that a service user can have an articulate understanding of the effectiveness of the LMHC professional and was able to identify when skills were lacking. It is then up to the healthcare services to ensure that they have a derived set of competencies that will ensure that service users' expectations are met. Amongst the competencies set out in the LMHN Framework (Hart & Eales, 2004) was the need for LMH nurses to have competencies in undertaking assessment.

Through partnership the assessment can get to the route of the problem. Implicit in the framework for person-centred care are the elements of the concept of partnership, which apply to the assessment by LMHS. The particular word - partnership - was not identified within the person-centred care framework. However, the issues of importance in the assessment phase of the service user's journey fit with the care process aspects of engagement, working with the patient's beliefs and values and having a sympathetic presence (McCormack & McCance, 2010), figure 7.2. From the care environment phases of the person-centred care framework, the importance of appropriate skills mix and shared decision making can be seen to map to the core aspects of assessment as shown on the conceptual map, namely 'I have the opportunity to talk', 'when I am assessed it makes sense and is relevant' and 'staff have clinical knowledge'. Thus, the argument is further made that the use of the person-centred care framework could offer LMH professionals a means to reflect upon their practice as well as the use of the conceptual map derived directly from the experiences of LMH service users.

The assessment phase of the journey is the beginning of the contact with the LMHS directly and the detailed process of assessing the service user. Service users have been able to articulate an array of requirements for the competence and skills that the LMH professional requires in order to work in partnership with them. Partnership involves the concept of a personalised assessment that reaches an understanding of the individual, at this stage the involvement of the service user in the decisions about their care need to begin and can then flow into the outcomes phase of the journey. At this point service users have negotiated much of the journey already with the build-up to the referral or the presentation at the ED and the experiences on their arrival or how they are treated on an in-patient ward before the intervention of the LMH team. From a temporal perspective the assessment aspect of the journey may well be quite a short aspect of the journey. However, it is a crucial aspect of the journey in terms of its importance to whether the service user can move to a place of hope, rather than hopelessness because this is the opportunity to tell their story and be listened to which is one of the strongest themes to present in the analysis of these data. The retelling of the story is likely to help the service user to make their own connections about the experiences they have had and the meaning, hence allowing them to start to slot together the pieces of the jigsaw (figure 6.5) and get to the root of the problem.

#### **7.4.5 *Liaison Mental Health service outcomes - Identifying a plan for the future***

Hope is identified in the conceptual map in terms of the overall direction of travel and also as the overarching definition in regard to the LMHS outcomes, the final leg of the journey through LMHC. In order to reach a sense of hope or hopefulness it is necessary to travel along a road where you have recognised that you have a problem that you need to seek help for, i.e. the psychological distress. The need to have received positive assistance on arrival at the ED or in obtaining a referral to the LMHS from a general hospital ward and furthermore be provided with person-centred care which engages you, in partnership with the LMH professional. This partnership facilitates the assessment and identification of solutions for your psychological distress.

##### **7.4.5.1 *From hopelessness towards hope***

Hope has had a long association with nursing, (Cutcliffe & Herth, 2002a; Cutcliffe & Herth, 2002b; Nekolaichuk, 2005; Cutcliffe & Koehn, 2007; Koehn & Cutcliffe 2007;), and hope has a very clearly outlined role in the recovery concepts applied to mental health care (Bonney & Stickley, 2008; Shepherd et al, 2008). In the concept of recovery, as applied to mental health care and mental health service user experiences, hope is the primary aspect that needs to be felt by the individual and instilled in the practice approach of the professionals. Hope explains the feeling that service users in this study identify having as a consequence of a positive experience of entering into

and completing their journey through LMHC. The Oxford Dictionaries defines hope as

*“a feeling of expectation and desire for a particular thing to happen”*

(Oxford Dictionaries, 2013)

Hope, as applied to health care, is not a simple construct, as the dictionary definition at first glance suggests. In her critical analysis of hope, Nekolaichuk (2005) deliberately and carefully avoided providing a definition. However, based on the themes of her analysis she presented a set of working assumptions about hope based on hope themes. These working assumptions included that hope is universal yet also intensely personal, hope is complex, therefore some of the components may never be articulated, and that it may or may not be predictable but appeared to be a universal personal value and to be primarily but not exclusively forward looking. This presented a much more complex articulation of the aspects of hope and was more akin to the complex and multifaceted experiences from the study findings.

Hope has been chosen rather than similar words such as optimism because where it is discussed in the health literature it tends to have an association with goals (Cutcliffe & Herth, 2002a) and it was clear that for service users in this study having a clear action plan and follow-up was necessary for their journey through LMHC to be complete.



Hopelessness is the direction of travel if the approach and interventions taken by the LMHS are not ones which instil hope in the service user. Hopelessness is also a description of how service users feel when entering the service, the level of despair or hopelessness is that which alerts the service user, their family and carers, or the professionals involved in their care that they are in need of help for their psychological distress. So the antipathy of hope follows the service user along their journey and any movement towards hope and hopefulness can be thwarted by the manner or lack of intervention and through the approach taken either by general hospital staff or LMHC staff towards the service user. In a very recent paper Parkes and Freshwater (2012) also used terminology very similar to that presented here to summarise their findings from interviews with women in forensic services who have self-harmed. Their paper's title begins '*The journey from despair to hope..*', which suggested many resonances with the current study and it was possible to find some common themes namely, within their "*A brighter future*" theme they identified constituents including "*developing new coping skills*", "*being heard/ listened to*", "*being believed*" and "*finding someone who cares and understands*".

Parkes and Freshwater (2012) were carrying out interviews with the women who had experience of self-harm to understand how they chose to express their emotions, but data gathered also enabled them to look at what reduced the women's self-harm or harm to others. In the paper, Parkes and Freshwater did not discuss why they have chosen the overall phrase of 'journey from despair to hope' for the title of the paper and these terms were

not discussed within the body of the paper. This paper is remarked upon primarily because in searching out literature on hope and mental health service user experiences at first glance it appeared to be offering an articulation of hope from the mental health service user perspective, however rather disappointingly the use of the term was not considered within the paper. The paper does however suggest that there are similarities between service users who self-harm and more widely those who present to LMHS with other forms of distress. Again similar to the present study Lindgren et al (2004) made the connection between the positive impact of instilling hope or as they termed it 'hopefulness' within service users. The nine women in their small study, who had been in contact with mental health services rather than the ED, general hospital or LMHC, identified positive experiences as those that fostered hopefulness within them.

In Cutcliffe's most recent discourse on hope (Cutcliffe & Koehn, 2007; Koehn & Cutcliffe, 2007), and also in less recent work (Cutcliffe & Herth, 2002a; Cutcliffe & Herth, 2002b) an argument was presented for a more logical and coherent approach to the study of hope in nursing and more specifically mental health nursing. The case was made that the accumulating body of literature about hope does not build upon previous studies and was not sequential, and that it was frequently derived from single centre or single population research.

The study presented here makes just those mistakes, if they are mistakes? What was not acknowledged directly but was in Cutcliffe's recommendations for future work was that almost all of the studies that identify hope in the last ten years have not set out to research hope, rather through qualitative in-depth interviewing of individual groups they have discovered the links between their original interest in exploring that group's experience and the relationship to hope. What there can be no argument about is the need to make greater sense of these disparate data which could, as Cutcliffe and colleagues suggest, be obtained by the use of meta-synthesis of qualitative studies whose findings include the importance of hope to service users, in order to create a more coherent theory of mental health service users experience of hope. The findings of the current study could be incorporated into the meta-synthesis thus including a new perspective from a previously omitted perspective of LMHC service users.

#### *7.4.5.2 Inter-personal effectiveness helps to piece the jigsaw together and instil hope*

The interpersonal effectiveness of the LMH professional and all those staff which the service user comes into contact with has been presented as key to ensuring that the service user continues in the correct direction towards hope and an effective navigation of the system. Recent literature reviews and recent studies in mental health settings that have considered the impact of hope have all identified that these interpersonal skills are very important to effective care (Nekolaichuk, 2005; Cutcliffe & Koehn, 2007; Koehn & Cutcliffe, 2007). The impact of good interpersonal skills came through

strongly in the current study as did the impact of poor skills on increasing the feelings of hopelessness and potential for harm. Cutcliffe and Herth (2002a; 2002b) present a number of models of hope, the current study does not encompass all of the elements, however this is not surprising because most studies undertaken that attempt to develop a model or conceptualise hope are looking over longer periods of care than the maximum of a few hours within the ED and most commonly a few weeks in the in-patient general hospital setting. When an in-patient service users are seen over a period of weeks, interventions and assessments are likely to be of no more than one hour. It is striking to note from the current findings that such short interventions are potentially therapeutic in and of themselves and that the impact of the brief interaction should not be underestimated.

In summary, hope is a complex personal experience, which can be absent or depleted from those who encounter LMHS. Through very brief but intense therapeutic interactions with LMH professionals service users begin a recovery journey, the beginning of which is the move from a position of hopelessness to one of hope and the ability to see that the situation can improve for the individual. In order to move from this position of hopelessness towards hope and to reach the end of the journey through LMHC the service users identified that they needed to leave with a greater understanding of the psychological distress that they were experiencing. The analogy of fitting the pieces of a jigsaw together has been used to represent these aspects of the process. Traveling the outcomes section of the road the service user needs to be supported to identify coping strategies that will

enable them to continue to recover from their psychological distress, there are a myriad of options available, dependent on the individual situation and as service users reported what they expected to occur as an outcome may be superseded by alternative ideas drawn from the experience of the LMH professional.

*“The last time would probably have been more profitable to my health than the first two, especially the second visit. It's being talked to, it was giving me coping strategies that weren't not medical that I could apply to myself.”*

(Caroline)

Caroline then goes on to explain that she was referred to a voluntary agency for immediate help whilst she stayed on NHS waiting lists for other services,

*“I mean what she did do was try to, you know, she did try to bring forward my appointment, yes that was May I saw her, May or April this year I saw her, cause then I had an appointment in June and she tried to speed up my appointment for seeing the psychiatrist but what she did was like suggest was you know, for me to go to Xxx House. “*

(Caroline)

This is therefore why not only the skills and competence of the LMH professional are important, but also the local knowledge of service provision that can enable service users to move to engage with relevant services. It is argued here that the movement from hopelessness towards hope indicates that the assessment and outcome planning of the LMHS intervention is, when conducted with a person-centred ethos a therapeutic intervention in and of itself.

#### *7.4.5.3 Creating a safety net for the future*

Ideally the service user leaves the service with a clear and relevant action plan and a sense of follow-up they were also, where it was offered, very pleased to receive the offer of returning if they needed to. This created a safety net for the service users. The service users did not always make use of this offer, seven of the seventeen service users interviewed had used the service once, the other ten service users had made a minimum of two visits and four had made multiple visits to the service for further support and intervention. The offer of 'returning if you need to' was a valuable safety net, however service users acknowledged that they did not hope to have to use the service again,

*“SE: How accessible do you find the service?”*

***Int: very***

*SE: OK,.....in the sense of that you can go anytime and it will be there?*

***Int: Yes (OK) .....though I hope to never have to use it again.....”***

(Mark)

This concept of not wanting to use the service again acknowledges the level of distress encountered in order to want to access the service and the hopefulness of a recovery. In preventing further visits follow-up is identified directly by service users as an area for improvement, because not everyone experienced this begin offered. Follow-up is not frequently commissioned as part of LMHS provision (JCPMH, 2008), and service user experiences in this study suggest that it should be. This could take the form of a telephone call. Some service users did return because the action plan and treatment offered within it was not effective or did not occur in a timely fashion. If follow-up were undertaken these issues could be rectified or explained to the service user and might avoid the need for return to the service. Knowing from the findings that service users reach a level of severe psychological distress before presenting to the service or asking for referral and the issues of potential harm already discussed it can be argued that a follow-up contact would prevent deterioration for those service users where the action plan is not effective.

### **7.5 Relationship-centred Care: a proposed model to integrate the policy drivers and the service users' needs**

Within the study to date, an argument has been made for the application of the person-centred care model (Gerteis et al, 1993; McCormack & McCance, 2006), most frequently associated, with older adult care, to the field of LMHC. However, as the point of concluding the study and considering the recommendations arrives, it becomes clear that the attitudes, knowledge and skills of staff within the practice area impact greatly upon the service user experience. Because LMHC is an interface for physical and mental health care provision service users are in contact with professionals trained to support those with mental health needs and also those that are not. In order for all professionals to engage in effective care consideration is needed as to not only the needs of the service user, through person centred-care, but also the needs of the staff that will provide that care.

For change to occur in the service user experience we will need to provide education which builds skills and knowledge in mental health care and addresses negative attitudes towards mental health needs. The relationship centred care model does just this in moving care forward from simply acknowledging the needs of the service user to also consider the needs of those caring for them (Tresolini & The Pew Fetzner Task Force, 1994; Nolan et al, 2004). The relationship-centred care model has other benefits, namely in more recent publications the impact of the organisation and application of the model to organisational change has been considered (Safran et al, 2006; Suchman et al, 2011).



A model which incorporates the organisation is important in considering the service user experience of liaison mental health care because change is required within the general hospital and the ED to ensure that psychological distress and mental health issues are responded to more effectively. The education and support of individual clinicians and groups of clinicians will be vitally important, however as Fernandes (2011) and the current mental health strategy (HM Government, 2011) identify mental health issues are part of general hospital care and should be afforded an equality of care which the service users within this study have not always encountered. For this to occur organisational change will need to happen akin to the impetus and drive which has recently been placed on developing dementia friendly general hospitals (DH, 2009). The improvement of dementia care within hospitals required identified leads at a senior management level to drive forward the initiatives required, bringing forward improvements in LMHC which encompass commissioning and move LMHC from the realms of a mere project for the few (Aitken, 2007), to a central aspect of all care provision will require mental health to be integrated at all levels of the organisations.

### **7.5.1 The six senses framework and a fit with the service user's journey**

Fundamental to the notion of relationship centred care, as set out by Nolan et al (2004) is the senses framework where all those involved in care-giving, including the service user have needs in six domains:

- *“security – to feel safe within relationships;*
- *belonging – to feel ‘part’ of things;*
- *continuity – to experience links and consistency;*
- *purpose – to have a personally valuable goal or goals;*
- *achievement – to make progress towards a desired goal or goals;*
- *significance – to feel that ‘you’ matter.”*

(Nolan et al, 2004 pp49).

Categories within the service user experiences and translated into the conceptual map resonate with the above senses framework, for example:

- Security – “when I am assessed it makes sense and it is relevant”
- Belonging – “kept informed, waiting is explained”
- Continuity – “I can return I if need to”
- Purpose – “greater understanding of the psychological distress”
- Achievement – “I have a clear plan and follow-up”
- Significance – “I attend I am prioritised and I am seen”

What this study has not sought to consider but what would be required for the implementation of the relationship centred care model within LMHC would be the development of the application of the sense framework to the mental health and non-mental health professionals and the wider organisation. Furthermore consideration would need to be given to how the framework would improve the engagement of all concerned in the provision of more effective mental health services within the general hospital setting.

## **7.6 Study limitations**

The discussion now moves to consider the limitations of the study. Two limitations are considered. These are the limitations of the service user involvement in the study and alternative approaches to the research of service user experiences.

### ***7.6.1 Service user involvement in the study***

The interview schedule was piloted with a service user and carer. Validation of the previous thematic analysis of these data was presented to the research steering group, which included ED practitioners, LMHC professionals, a service user, a carer, and service managers. The constant comparative analysis of these data undertaken as a secondary data analysis for this study has not gone through a process of member checking with the original service users (Kelly, 2010). This is partly because the use of secondary data places a considerable time gap between the original

interviews and the current data analysis making it challenging to undertake this form of member checking with the service users in the original data set. This could be seen as a limitation of the findings.

Gaining access to service users for interview proved challenging, many more were approached than agreed to participate in the study and details of those who did not participate do not explain why they did not come forward. Challenges of engaging service users in sharing their experiences of LMHS is not limited to the study and is an acknowledged issue for services attempting to gain validation through the PLAN system (Palmer, 2013).

### ***7.6.2 Service user-led research, developments in approach***

The service user led research movement has developed vastly over the course of this study and the requirements for service user involvement in all research and the development of service user groups such as the one at City University London have had an important impact on how service users impact on the development of research proposals, research design and data analysis. At the inception of this study there were important changes occurring in the development of service user led research, namely the work of people like Diane Rose (Rose, 1996; Rose, 2001; Rose 2003) and Peter Beresford (Beresford, 2003).

This study argues that hearing the service user's voice and experience is vital to development of effective services and research conducted solely by service users is one way to address this imbalance. Beresford (2003) argues that all approaches to exploring service users experiences have their place, including the interpretation of service user experiences by those who do not have direct experience, however what Beresford is clear about is the need to also include experience identified and interpreted by service users, the author would wish to support this notion and to identify that what this study cannot do is present the service user experience directly, this study is an interpretation of the service user experience by an insider researcher with direct professional experience of the services and situations encountered by the service users who gave their time and experience to this study. It can be argued that as a first attempt at a representation of service user experiences of LMHS this study moves the knowledge base closer to the lived experience of LMHC. Government strategy towards service development and delivery would suggest that service user involvement and voice is a 'must do' activity and not one that should be on the side-line, however this literature review, the conclusions of Parsonage et al (2012) and the experiences of the PLAN accreditation committee (Palmer, 2013) suggest that engaging service users in evaluating LMHC whether as a research study or a service evaluation is very challenging. More work must be undertaken to involve service users in these activities.

### **7.6.3 *Utilising Secondary data***

The argument has been made in section 2.6 and section 4.1 that secondary data analysis is a valid methodological approach for this study; furthermore that the researcher had a duty to present, in full, the stories and experiences of those who were interviewed about their experiences of LMHC. Never the less the use of data collected in 2000 lends itself to the criticism that as has been shown by the literature review service provision has altered since the data collection occurred. The question arises as to whether the findings of the study can be considered to be contemporary. The literature review up to the completion of the study has identified that no other in depth experiences of the insights into the experiences of service users of LMHC exist and as such that the experiences provide us with potential new insights into the service user experiences. In maintaining clinical contact through direct work and engagement with LMH practitioners through a variety of forums (these are identified in section 8.5) the researcher has remained convinced of the resonance of the experiences of those service users with the current service user experience. The review of more recent literature regarding service users' experiences in related areas has also suggested that there are resonances from those findings with those of the LMH service users. Further data collection using experiences drawn from a number of different services using primary data is required to consider if this analysis has captured all the aspects of the service user experience of LMHC and as is suggested by this study retains a contemporary view of the experience. Addressing this limitation through undertaking such work could form part of post-doctoral work.

## **7.7 Moving forward with research into and understanding of LMHC service user experiences**

These data do appear to be the first attempt to acknowledge the service user experience in the context of LMHC, using an in depth constant comparative analysis, and as such begin a body of experiential data and discussion that can proceed and build into the future of integrated health & social care service developments. The discussion has attempted to cross reference and compare these findings with those of related service user experiences, for example self-harm (NICE, 2004) and depression (DIPEX, 2008). The discussion suggests that there are similarities between LMHC service user experiences and those with other mental health experiences; however this study is unique in capturing the experience from the point of view of LMHC. There are a number of aspects of the whole experience of psychological distress and LMHC that appear to offer unique insights that could be developed further in the future. The following recommendations section sets out how these insights can be taken forward.





## 8 RECOMMENDATIONS

LMHC is currently dependent on the local recognition of the need for mental health care in the general hospital. There are a number of sets of guidance (RCPsych, 2004; Aitken, 2007; AoMRC, 2008a; AoMRC, 2009; JCPMH, 2012). Those from the Royal College of Psychiatrists are currently being reviewed and a revised position statement and guidance is expected from the Royal College of Psychiatrist imminently (Butler, 2013). There exists a national strategy which incorporates the overarching concept of '*No health without mental health*', not a new mantra within LMHC, having been coined by the AoMRC in 2009 in their ALERT Report which attempted to address the current issues relating to LMHC, namely:

Awareness of the link between physical and mental health

Liaison Mental Health services

Engaging patients and carers

Reorganisation, quality and commissioning

Training and education

(AoMRC, 2009 pp5)

At the London Wide Liaison Nurses Special Interest Group, of which the author is Chair, it reflects the variety of service models: From 9am to 5pm in-patient only services, to 24 hour whole hospital provision and encompassing nurse led with no psychiatrist support to fully formed multi-disciplinary teams incorporating nurses, psychiatrists, psychologists and / or social workers.

Funding of the LMHS is often tenuous and frequently comes under threat when budgets are reconfigured. Funding may come from the acute hospital trust or the mental health trust or may be shared. It may even come from one off grants to start up services with no long term secure funding. Some services cover all ages, while some cover only working age adults or older adults. To summarise, there is no consensus as to a model of LMHC provision. Amalgamation with home treatment teams comes and goes as a proposition which, when it occurs, limits the provision to service users who present with severe mental illness or significant self-harm and does not cover in-patient general hospital care. Some services are able to offer formal in-house training for their non-mental health colleagues, while others are not. Many offer this service without being directly commissioned to provide it as they believe it has a benefit. The review by Parsonage et al (2012) would suggest that education of general hospital colleagues is where most cost-benefit is to be obtained from LMHS intervention.

What follows is a set of recommendations which attempts to incorporate the findings from the different aspects of the research objectives, namely, the review of policy and research literature and the findings from the research into service users' experiences of using a LMHS. The production of policy and practice improvement recommendations for contemporary liaison mental health, based on the application and findings from the study, is the final objective of the study. The recommendations have been structured to address policy, practice, research and education. Finally the chapter

considers the author's personal impact upon LMHC policy, practice, research and education that has been associated with this research.

## 8.1 Recommendations for Policy

The literature review provided an overview of the current policy and guidelines for LMHC, having considered the increasing number and variation of documents which encompass LMHC and noting some concerning absences of LMHC from policy documents (HM Government, 2011). This section draws on the findings and discussion of the findings as well as the conclusions of the policy review to make recommendations for future policy documents.

Policy
<b>Recommendation 1: Ease of negotiation and navigation of services</b> When policy, practice guidelines or service specifications are developed relating to LMHC, consideration should be given to how service users will know about the service and how easy it will be to navigate into and negotiate through from the service user perspective.
<b>Recommendation 2: Widen access for psychological distress to reduce harm</b> Policy documents need to change to ensure that access to services does not place too constricted access criteria, meaning that psychological distress has to deteriorate to the point where potential harm becomes actual harm. Current government policy (HM Government, 2011) reflects this.

**Recommendation 3: The ED is a “front door” for mental health needs too**

As Fernandes (2011) identified, the ED needs to recognise that presentation of mental health needs is going to occur and services should be designed and funded to support this need.

**Recommendation 4: Every hospital should have a LMHS**

LMHC has the potential to improve the service user journey where psychological distress is part or all of the presentation. The case for this has been advanced both economically (Parsonage et al, 2012) and from the service user perspective.

**Recommendation 5: Commissioning a responsive secure service**

Commissioning of LMHS should be such that it is able to offer a responsive service incorporating current guidance and the following:

- 24 hour access (Parsonage et al, 2012) for acute hospitals
- Prompt responses
- Support and education for the general hospital staff both formally and informally
- A service that does not have overly limiting referral criteria (Lyons et al, 2009)
- A service that secures experienced staff through long term funding
- Capacity to engage service users in feedback
- A policy of measuring service user reported experience and outcome measures
- Models that are flexible because the evidence for the RAID model is limited.

**Recommendation 6: Acknowledge the role of LMHC in the No Health Without Mental Health agenda**

Current government policy on the improvement of mental health care, including within the general hospital, should more clearly identify LMHC care at the heart of this initiative.

**Recommendation 7: Senior leadership within the general hospital to champion positive mental health care**

Consideration should be given to the same level of senior support and leadership which is reflective of that required in the National Dementia Care strategy (DH, 2009), with the aim of promoting positive change in staff attitudes and knowledge of mental health needs.

**Recommendation 8: Ensure the current research feeds into the national Psychiatric Liaison Accreditation Network Standards**

The findings and particularly the conceptual map may assist the PLAN team in reviewing the processes adopted and the methods used to engage service users.

## **8.2 Recommendations for practice**

The findings and discussion have identified that the brief involvement of the LMHS in a service user's journey can have a therapeutic value which can impact upon the ability of the service user to negotiate and navigate through their required health care. As well as the therapeutic nature of the assessment, the LMHS needs to play a part in sign posting the service user in completing their journey. Service users identify that they would prefer that the LMHS was involved in that onward journey through various follow-up processes. Given the poor experiences service users can have in the ED, where service users are supported by follow-up this should work towards the development of safer and more desirable safety nets than accessing the LMHS via the ED. Within the discussion and the conceptual map (Figure 7.1) it has been identified that services and staff within the general hospital are

not always equipped to identify and manage mental health issues. In acknowledging that the general hospital will need to effect change at all levels the relationship-centred care model has been proposed as a possible means to support all in working towards meeting the needs of service users in psychological distress.

## Practice

### **Recommendation 9: Accept mental health presentations in the ED and offer equality of care**

All those working in the ED need to accept that currently people with mental health needs will present and care should be provided that is equitable to that offered to other presentations.

### **Recommendation 10: Adopt a model of LMHC such as Caplan (1970)**

Caplan offered an integrated model of LMHC ensuring that LMHS offer not only direct patient care, formal and informal support and education to the staff undertaking physical health care for a service user but also anticipates involvement of the LMHS in service development and design across the whole environment.

### **Recommendation 11: Raise awareness in in-patients of the available LMHS**

Consideration should be given to informing all in-patients that support is available within the hospital for mental health issues and psychological distress that impacts upon their care. This could be verbally and/or through leaflets. Verbal information can be useful where service users are unlikely to be literate in their first language, for example the Bengali population.

**Recommendation 12: Adopt person-centred care**

In engaging with the service user, ensure a person centred-care approach is adopted in LMHC and the wider ED and general hospital.

**Recommendation 13: Ensure each service user has the opportunity to tell their story during the assessment**

Service users welcome the opportunity to tell the story of their psychological distress. This should include obtaining an understanding of the pre-contact phase of the psychological distress, including any false starts they may have had in engaging with services up to this point.

**Recommendation 14: Offer support to fit the “jigsaw” of understanding together**

When conducting a therapeutic assessment and devising effective outcomes with the service user consideration should be given to the jigsaw (figure 6.5) and what needs the service user has to understand their psychological distress and diagnosis, to understand symptoms and to develop coping strategies. The missing or incomplete pieces of the jigsaw should affect the therapeutic discussion and the development of an action plan.

**Recommendation 15: 24 hour follow-up for all**

Consideration should be given to formal follow-up by telephone of all service users following discharge. Given the potential for harm this mirrors the recommendation following discharge from in-patient care in the recommendations of the 2006 Confidential Inquiry into Homicides and Suicides (The University of Manchester, 2006). This could be undertaken by the care co-ordinator where the service user is known to mental health services.



**Recommendation 16: Follow-up clinics**

Consideration should be given to formal follow-up clinics offering brief psychological intervention where services do not exist to offer the interventions required or are likely to prove inaccessible to service users for example due to long waiting lists.

**Recommendation 17: Offer service users useful information when they are discharged**

Patient leaflets given to service users at the point of discharge should include information regarding accessible information on mental health conditions, e.g. health talk on line, national helplines, e.g. the Samaritans and local support groups and information.

**Recommendation 18: Accept that LMHC in the ED represents a last resort safety net for service users**

The offer to return if you need to is a valued safety net for service users and the option to do this if the action plan is not effective or no other services are available to the service user in crisis should be an accepted legitimate role for LMHC.

**Recommendation 19: Improve crisis planning with mental health service users**

LMHC staff should consider taking a more active role in developing service users' crisis plans. Ensuring LMHC staff feedback to care co-ordinators the need for a more detailed and appropriate plan above and beyond advising attendance at the ED if a crisis occurs. Where coping strategy work is undertaken with the service user within the LMHC process this should feed into the service user's crisis plan. Crisis plans should work to develop alternatives safety nets to the ED.

**Recommendation 20: Utilise relationship-centred care as a means of integrating the support required for all regarding providing effective mental health care in the general hospital.**

Relationship-centred care (Nolan et al, 2004) offers a means of integrating the needs of all involved in mental health care including service users, carers and staff therefore consideration should be given to its utilisation as a model for practice.

### **8.3 Recommendations for Research**

Whilst there is a reasonably broad data set for understanding the experiences of people who self-harm within the ED and their interactions with the ED staff there does not appear to be a systematic overview of what we know about service users overall experiences of mental health care when in psychological distress and more specifically in accessing mental health crisis services such as LMHC and Home Treatment (Lyons et al, 2009). Within the updated literature review it has been identified that the evidence for the

structure, process and outcome of liaison mental health care services remains patchy in availability and furthermore inconclusive. Whilst this study makes a contribution to knowledge and evidence about the experiences of service users of LMHC, this is based on data from a single case study site and further research will be required to verify these findings on a wider scale. There is an argument for other methods of service user experience data being obtained including via service user led and collaborative research (Beresford, 2003; Owen, 2005; Frankham, 2009; Morrow et al, 2012).

## Research

### **Recommendation 21: A meta-synthesis of mental health service users' experiences of crisis provision.**

A meta-synthesis of the qualitative research data on service users' experiences of mental health provision for crisis presentation, which draws data not just from a single service model should be completed to inform the understanding of and service development related to crisis care. This will assist in developing the knowledge base in this area and identifying the gaps in our understanding and evidence base for service provision.

### **Recommendation 22: National research to verify the service users' experiences of LMHS**

Research is required to understand, still further, the experiences of service users of LMHC drawing samples from other areas of the country and other service models, in order to make comparisons with the current emerging theories and, if confirmed, to develop them further.

**Recommendation 23: National research to evaluate a number of different LMHC models**

Evidence for the adoption of a single preferred LMHS model is not available. High quality multi-centre research is required to evaluate a variety of models from an economic, clinical outcome and service user experience perspective.

**Recommendation 24: Establish what approaches would work for improving mental health care in the general hospital**

Evaluations of the effectiveness of education are small scale (Palmer et al, 2007) and therefore lack generalisability. Research is needed to establish what approaches to improving the knowledge, skills and attitudes the general hospital workforce are effective, be they educational or otherwise.

#### **8.4 Recommendations for education**

In order to work towards service users with mental health issues or psychological distress obtaining a supportive service within the general hospital setting there is a need to consider what both LMHS and the wider academic setting should offer those who currently work within the general hospital setting. Consideration is also required regarding the training of the future workforce. The needs of LMHC professionals themselves also need to be considered.

Education
<p><b>Recommendation 25: Further educational input is required for the current workforce</b></p> <p>LMHS must play a role in both formal and informal education of the general hospital workforce with regard to mental health awareness. Consideration should be given to incorporating mental health elements in all continuing professional development, particularly for those intending to or working in the ED.</p>
<p><b>Recommendation 26: Educating the future workforce for offering mental health care</b></p> <p>Those training to work within the general hospital setting need to be better prepared for providing care and support for those with mental health needs; particularly nurses, who offer the majority of care within the general hospital.</p>
<p><b>Recommendation 27: Utilise the conceptual map: service user journey through LMHC in continuing professional development courses for LMHC.</b></p> <p>The conceptual map offers a means for LMH professionals to consider the service user experience and reflect upon how it can be incorporated into their day to day practice and how it might inform service user evaluation of individual services.</p>

## 8.5 The impact of the research to date and planning for the future

As the research has progressed the author has attempted to bring the developing knowledge and analysis into her practice as a liaison mental

health nurse and also into her substantive position within the mental health academic world. The dissemination of the findings from the secondary data analysis to a wider national and international audience needs to be considered.

#### ***8.5.1 Developing a LMHC module at BSc for CPD***

As part of the process of engagement with the LMHN Special Interest Group it became apparent that no specialist post registration education existed for nurses working in LMHC. As a consequence the author set up a degree level module in LMHC at City University, London in May 2004, the module has run annually since then and attracts primarily a local LMHN audience; however participants have come from as far afield as Jersey and is open to all LMHN professionals, social workers do attend occasionally. The content of the module is based upon the LMHN competencies (Hart & Eales, 2004). The module needs to be updated to reflect the findings of the current study and to incorporate the conceptual map of the service users' journey through LMHC (Recommendation 27). It would also be pertinent to include the "jigsaw" (figure 6.5) in the teaching on the module (Recommendation 14). The concepts of person-centred and relationship-centred care should be introduced into the module (Recommendations 12 & 20). The module already includes consideration of Caplan's model (Caplan 1970) and the role of the LMH nurse in crisis planning (Recommendations 10 & 19). In 2014 the module will also run at MSc level to better meet the improving academic education attainment of those who currently work in LMHC.

### ***8.5.2 Involvement in the education of ED nurses and the wider nursing workforce***

As the author's specialist knowledge has developed she has attempted to find places within the continuing professional development courses at City University, London that would be complemented by mental health input. Both the MSc Advanced Nursing Practice Assessment module and the Emergency Nurse course contain input on understanding, assessing and managing mental health issues. The experience of the author in providing this input, is that the level of knowledge is very variable and invariably the input needs to begin with a basic introduction and opportunity to share experiences. Often these experiences from non-mental health staff mirror the difficulties of the service users in this study in so much as they have often struggled to obtain assistance from mental health services for the patients they consider to require mental health support.

During teaching, when considering case studies assistance is most often providing in considering how to access services and what service are available. Therefore my educational agenda and goals have developed to offer sessions which ensure that the participants leave feeling more equipped to undertake assessment. Enabling them to present the assessment in a manner that is likely to gain the attention and action of primary care and the secondary mental health services; thus assisting the professional non-mental health staff to assist the service user to navigate

into mental health care when required. Those attending the MSc Advanced Practice Assessment module are frequently senior nurses working with complex long term conditions where mental health issues are sometimes involved, Parsonage et al (2012) identify LHMC in the primary care sector with services for long term conditions as a developing aspect of LMHC. Supporting nurses on the above programmes is a local step towards addressing recommendation 25.

### ***8.5.3 Mental health awareness training within the general hospital***

The conduct of the primary research led to the interest of the Deputy Director for Nursing in the respective trust and a commission to provide mental health awareness training. This training, which was developed and led by the author, was open to all staff within the Trust, however the majority group who attended were nurses and health care assistants. Approximately 350 staff received the training over a four year period from 2003 to 2007. The funding for the project ended not long after the committed director left the trust. The ending of the training highlights the importance of recommendation for a senior lead for mental health within each acute hospital trust (Recommendation 7). The training focused on interactive sessions exploring staffs' perceptions and understanding of mental health and increasing knowledge about various mental health issues. The sessions covered mental health assessment and participants also used case studies that they brought to the sessions to consider practice improvement in supporting those with mental health issues within the general hospital. This is an example of the formal teaching required by recommendation 25 to improve the ability of the



current workforce in supporting service users with psychological distress and mental health issues. LMHS can and should provide this type of educational input when implementing the Caplan model (1970) for LMHC (Recommendation 10). In the final year of the educational project services which sent ten or more people were offered a follow-up visit where they could discuss individual challenges and concerns within their own unit, this style of teaching represents an example of a more informal approach to education, which can often fit into regular unit meetings or can occur in the context of individual patients.

#### ***8.5.4 Policy and practice development***

Connections made through the course of the research and the developing knowledge and skills base of the author have led to her engagement in a number of areas of LMHC policy and practice development at a national level.

##### ***8.5.4.1 Chairing the London Wide Liaison Nursing special Interest group & LMHN competencies***

The author became involved in the above special interest group at the beginning of her involvement with LMHC. This involvement led to the development of a competency document for LMH nurses, where none had previously existed (Hart & Eales, 2004). These competencies continue to be utilised in personal and professional development for LMH nurses, job description development for new services (Byrne, 2013). Subsequently the

author has chaired the special interest group for the last 5 years, this enables her to support LMH nurses from within the London area and more widely. The mailing list for the forum maintains contact between over 80 liaison nurses. Although originally a London based group nurses have now joined from further afield in order to gain support and share information. The group meets 5 times per year and each meeting involves service updates and a presentation of interest to the group. Authoring the LMHN competencies and chairing the special interest group which is supported by the Royal College of Nursing (RCN) has led to the author being invited to represent the RCN when a LMHN representative is required.

#### *8.5.4.2 Representing nursing on the Royal College of Psychiatrist PLAN*

##### *Accreditation Committee*

The author represents the RCN on the Royal College of Psychiatrists Psychiatric Liaison Accreditation Committee (Palmer et al, 2010). The committee is responsible for making recommendations as to the appropriate accreditation decision in respect of each LMHS which has joined the scheme, of which there are approximately 30 around Great Britain and the Channel Islands. The standards for accreditation include ensuring that the LMHS is appropriate staffed to meet contracted hours and responsibilities, ensuring appropriate policies are in place to maintain safety and attempting to obtain carer and service user feedback on the quality of the service. The LMHN competencies (Hart & Eales, 2004) is one of the documents that forms the basis of the PLAN standards. Each year the standards are reviewed and the author feeds into this process, including advising on

changes that need to be made to reflect the changing service user engagement agenda, for example the incorporation of the NICE guidelines on patients experience (NICE, 2011; NICE, 2012) is currently required. Service user and carer representatives also sit on the accreditation panel and can offer further more personal insights into the updating of the standards.

#### *8.5.4.3 Representing nursing in the development of the revised Royal*

##### *College of Psychiatrists Council Report 118 Psychiatric services to A&E departments*

The author has a further role representing LMHN for the RCN. The Royal College of Psychiatrists (RCPsych) has provided a variety of council reports that reflect a position on mental health services to the general hospital (RCPsych, 1994; 1996; 1997; 2004), the reports cover the ED, self-harm and psychological needs of medical and surgical patients within the general hospital. These reports are in the main considered out of date and are currently under review, being amalgamated into one document, the working title of which is, *“Liaison Psychiatry for every acute hospital: integrated mental and physical health care”*. This report is written with the engagement of the Royal College of Psychiatrists, College of Emergency Medicine, Royal College of Physicians, Royal College of General Practitioners, Royal College of Nursing, College of Mental Health Pharmacy, Society for Acute Medicine and the Psychiatric Liaison Accreditation Network. The aim is to offer a comprehensive statement on commissioning service structure through to clinical interventions for LMHC within the general hospital. This will represent

an update and amalgamation of a number of related documents primarily from the AoMRC (2008a; 2009) and current commissioning guidance (JCPMH, 2012); publication is anticipated in 2013. Recommendations 4, 5, & 6 will be addressed within the document.

#### ***8.5.5 Research developments***

As the study has developed and the educational impact of the author's activity gained momentum a successful research grant application was made to explore issues arising in the renal department of the case study site. The application was developed from an idea generated through offering the mental health awareness training in the general hospital. The mental health awareness training utilised case studies brought by the participants to explore mental health needs and psychological distress within their clinical areas. From these teaching sessions it became apparent that staff were reporting high levels of mental health morbidity coupled with disruptive behaviour. The research grant allowed for the study of the phenomena and to ascertain why such a situation should be the case. The research was undertaken at the case study site hospital funded by a grant from the case study site hospital research funds, the author was a co-author on the study, mainly involved in the development of the research idea, identification of the problem and engagement of the case study site haemodialysis units. The research ran from 2006 to 2009. The research study title was:

Developing Strategies for the Management of Disruptive Patient Behaviours  
in the Haemodialysis Units at Barts and the London Trust. (£98,935)

#### **8.5.6 *Publication of the findings of the study***

Findings from the empirical aspect of the current study have yet to be published; it would also be pertinent to consider publication of the updated review of the structure process and outcome of LMHS which forms part of the literature review. The author's publications within the field of LMHC are offered in appendix 11.

#### **8.6 Summary of recommendations and author's personal development related to LMHC.**

This chapter has attempted to draw together the recommendations from the review of literature and the gaps therein. Furthermore to identify the recommendations based upon the findings of the current study and the identification of the conceptual map: The journey of a service user through LMHC. Recommendations have been identified for policy, practice, research and education. There is a need for senior leadership within the general hospital setting in order to champion mental health needs and to review current practice ensuring that services are adequately commissioned to be able to respond to the service user need and to offer an effect intervention which is readily accessible. In order to be readily accessible the current and future workforce of the general hospital will need to be enabled to offer appropriate assessment and support to those with mental health needs and

psychological distress. A shift in mind set is required to ensure that mental health needs are supported and relationship-centred care offers a model which considers the needs of the service user, drawing on person-centred care principles, but also acknowledging that staff at all levels will have needs and require emotional support in order to care effectively. The chapter then identified the developments that the author has undertaken or engaged with since the inception of the study which have drawn upon the experiences and findings of the study, these include educational developments, including the development of the first continuing professional development module for liaison nurses. The author has also had an impact upon national guidelines for LMHC and accreditation of LMHS, these roles have developed as a consequence of the currently presented study. Publication of the current findings is a future goal for the study.

## **8.7 Conclusions**

### ***8.7.1 The research evidence base for LMHS***

UK LMHC must prove its worth from an economic perspective, the process of determining this has begun (Parsonage & Fossey, 201; Parsonage et al, 2012) with evaluation of a single service model, the RAID (Rapid Assessment Interface and Discharge) model in Birmingham, UK. However there are other aspects to evaluation of service provision, including clinical effectiveness and patient reported experience and outcomes. LMHC has yet to identify what matters to service users; this study has provided the first in depth consideration of the experiences of service users when using a LMHS. Service users spoke at length and in detail about their experiences and reflected upon those which enabled their journey and those which created barriers to improving their psychological distress. As with the economic evaluation, the findings relate to a single service; therefore there is a necessity to explore service users of LMHC experiences further and to conduct research into all aspects of LMHS provision exploring different models of care.

### ***8.7.2 Negotiating and navigating the system, a journey through liaison mental health care***

The service user experience is a journey, of which LMHC is a part. The mind set of professionals needs to change to align more closely with the challenges that this journey presents for the service user. The pre-contact that leads to an interaction with the LMHC needs to be taken into account,

and offered acknowledgement that the journey may not have been a positive experience up to that point. Professionals need to accept greater responsibility for supporting the service user to negotiate and navigate the system of healthcare, this needs to replace any perception that the service user is responsible for what the professional may consider an inappropriate presentation of psychological distress within the general hospital to recognise that the person did not know where else to go or had exhausted their own coping strategies. Service users should be empowered to take over the negotiation and navigation through a collaborative person-centred approach to care.

What this study offers is detailed information about the service users' experience of LMHC and how this experience can be improved. The presentation of a conceptual map provides an aspirational guide to how best to offer services to those in psychological distress within the general hospital and also identifies what services need to do to avoid creating barriers to a positive journey for service users. This provides a basis to integrate the service user perspective into future educational interventions, which will then require evaluation. LMHC professionals are charged within the integrated model of LMHC (Caplan, 1970) with the provision of both formal and informal teaching to general hospital staff in order to improve the general hospital response to service users who experience psychological distress.



### **8.7.3 *Relationship-centred care***

As the study has drawn to a close the pressures on ED's, urgent care and within the general hospital have come to the fore within the UK (Francis, 2010; NHS England, 2013). A recently completed document to assist EDs in meeting the needs of those presenting with mental health needs (CEM, 2013) represents, according to Hicks (2013), the most downloaded document ever produced by the Centre for Emergency Medicine and this occurred without any publicity surrounding the launch. This indicates a willingness and interest to engage with the needs of mental health presentations in the ED on behalf of the ED professionals. Therefore an opportune moment has arrived, to reconsider the approach to mental health needs within the general hospital setting. The service users experiences within this study offer a new view point of LMHC which has to date remained unexplored. Without a doubt LMHC must be seen to have a role to play in ensuring that the patients of the general hospital are afforded an equality of care for their mental health needs. The literature review has shown that there are many gaps in the evidence base for LMHC at all levels. This includes evidence to indicate what type of education interventions with general hospital staff can effect positive change. Relationship centred care offers a means to ensure that not just the service users are afforded a supportive response but also this model acknowledges that those attempting to offer care to psychological distressed service users will require support in order to meet those service user needs. The model also incorporates the organisational and community levels and seeks to engage all with the notion of effective care. In the context of the service user experience the model has

the potential to address issues such as the lack of sign posting for service users regarding where to find help when their own resources are not effective.

#### ***8.7.4 The opportunity for therapeutic intervention***

The findings of the study identify that service users are attempting to piece together a jigsaw to complete their understanding of and ability to manage their psychological distress. The jigsaw comprises three pieces, firstly the need to understand the psychological distress, which may include understanding that it is a mental health issue and where appropriate to understand the diagnosis. Secondly the service user wants to make connections between the labels and the symptoms that they are experiencing and then thirdly to be able to identify coping strategies. The findings have also identified that the assessment can be therapeutic in and of itself. In order to maximise the therapeutic nature of LMHC and maximise the positive outcomes for service users, the jigsaw model can help the LMHC professional to target therapeutic interventions at the right piece of the jigsaw. If pieces of the jigsaw are missing the professional will need to develop an action plan with the service user that addresses these remaining pieces. In effectively helping the service user to move forward in discovering the pieces of the jigsaw and putting them together, the LMH professional is more likely to assist the service user in moving from a state of hopelessness towards hope and therefore reducing the potential for harm both physically but also at a social level including relationships and employment.

## **8.8 Closing comment**

This study has explored in detail the context of LMHS, as revealed in policy and practice initiatives, alongside the experiences of people who have used liaison mental health services (LMHS), in the United Kingdom (UK). Tracing LMHS developments over the period of 1990 – 2013 has identified a paucity of research evidence in this area. Therefore, this study has contributed key insights into LMHS provision, informed by service users, who need to learn quickly how to navigate and negotiate a complex system (including health care staffs' attitude in approaching and understanding psychological distress) in order to obtain on-going hope for their personal recovery journey.

As a result of analysing service user experiences, I have identified a 'jigsaw' that represents three core aspects of LMHS intervention (section 6.3.3.1). In addition, rich material exposed from the service user experiences has enabled the identification of a conceptual map, (section 7.4) that represents the experiences of service users as a journey, delineated by four distinct phases of LMHC (pre-contact, arrival, assessment by the LMHS and outcomes). The end of the road, for most service users, is by no means an end point on their recovery journey, but represents a movement towards and the development of increased level of hope to continue with that journey. This is in stark contrast to the option of actual harm as a means to ending the journey and remaining in a state of hopelessness.

I conclude that LMHS offers but one route service users' access to navigate an improvement in their psychological distress leading towards a personalised route to a positive outcome. A positive outcome as supported in the literature can be recognised as a variety of things, including a process towards achieving a personally acceptable quality of life, and/or a return to a state of wellness.

The jigsaw (figure 6.5) and the conceptual map (figure 7.1) can be used as educational tools, to further inform professional health care providers, through taking into account, and acknowledging the complexity of the service users journey towards psychological wellbeing and recovery. Professionals need to understand and be continually reminded of their significant contribution to supporting service users to negotiate effectively the complex system of health care services. Such awareness needs to replace any perception that the service user is responsible, in terms of what the professional may consider an inappropriate presentation of psychological distress within the general hospital setting; utilisation of the relationship-centred care model can assist individuals and the organisation to explore these issues. Education and relationship-centred care can raise awareness and recognition that the person seeking help has most probably exhausted the extent of their personal coping strategies. I therefore conclude by acknowledging that service users need to be empowered to successfully negotiate and navigate LMHS, through a collaborative person-centred approach to care delivery. The adoption of a comprehensive model of liaison mental health care remains a priority across health and social care in the UK,

in order to achieve improved service user experience, cost efficiency and integrated physical and mental health care provision.



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## **APPENDICES**

### **Appendices**

- Appendix 1:** Callaghan, et al (2003) A review of research on the structure process and outcome of liaison mental health services. *Journal of Psychiatric and Mental Health Nursing* 10, 155-165.
- Appendix 2:** Full search strategy for the updated literature review of the structure process and outcomes of LMHS
- Appendix 3:** Semi structured interview guide.
- Appendix 4:** Initial letter of invitation to be interviewed.
- Appendix 5:** Follow-up letter to attend an interview.
- Appendix 6:** Information leaflet accompanying invitation to interview letters.
- Appendix 7:** Study information leaflet.
- Appendix 8:** Consent form.
- Appendix 9:** Example of an annotated coding memo for the category “opportunity to talk”.
- Appendix 10:** Diagram of axial coding and the relationship to the core Category.
- Appendix 11:** Authors publications in the field of LMHC.





## Appendix 1

*Journal of Psychiatric and Mental Health Nursing*, 2003, 10, 155–165

### A review of research on the structure, process and outcome of liaison mental health services

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CALLAGHAN P., EALES S., COATES T. & BOWERS L. (2003) *Journal of Psychiatric and Mental Health Nursing* 10, 155–165

**A review of research on the structure, process and outcome of liaison mental health services**

Liaison mental health services (LMHS) developed originally to address the mental health needs of people with physical illnesses in general hospitals and more recently to work also with people with mental health problems presenting at non-mental health services. The purpose of the present paper was to review empirical research on the structure, process and outcome of liaison mental health services using systematic review methods. Following a comprehensive search strategy, the authors reviewed 48 papers published between 1975 and 2001. There is an extensive international literature on LMHS, much of which describes the structure and process of liaison work. Studies evaluating the outcomes of liaison mental health services are fewer, and handicapped by methodological flaws, some of which are serious enough to cast doubts on the reported results. Professionals and clients value LMHS. LMHS based in accident and emergency (A & E) departments appear to ease the burden of general A & E staff, help clients access mental health services and reduce re-admission rates of people with mental health problems. There is little evidence supporting one model of configuring LMHS over another.

**Keywords:** health, liaison, mental, outcome, process, structure

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#### Introduction

Liaison mental health services (LMHS) developed on the back of increasing evidence that illnesses with biophysical origins often had psycho-social consequences (30–65% of medical inpatients are estimated to have psychiatric symptoms; Gomez 1987) and that they contribute significantly to the quality of medical care (Pevler & House 2000).

The origins of liaison mental health services have been traced to 1751 in the United States of America (USA) and the work of the Pennsylvania Hospital in Philadelphia (Schwab 1989). J. Montgomery Mosher is regarded as the first general hospital psychiatrist (Schwab 1989) and in

1909 was the first to outline basic principles of liaison mental health care. The sixth of Mosher's principles addresses the importance of mental health services liaising with other general hospital specialist services (Mosher 1909). Since the last part of the 19th century it is claimed that LMHS evolved in four discrete phases (Schwab 1989; see Table 1).

Liaison mental health nursing developed in the 1960s in the USA (see Robinson 1982 and Roberts 1997 for reviews). Liaison nurses were regarded as clinical specialists who provided consultations to general hospital nurses, educated general nurses and others about the care of patients experiencing mental health problems, provided specialized psychological care to patients and their families



## Appendix 2

### Search Strategy:

#### lit rev LHMN Jan2013 : combined databases

1. mental health.mp. [mp=ti, ot, ab, sh, de, hw, kw, tn, dm, mf, dv, tx, ct, bt, nm, kf, ps, sj, do, po, go, rs, an, ui, dw, pt]
2. limit 1 to english language
3. limit 2 to human
4. limit 3 to yr="2000 -Current"
5. psychiat\*.mp. [mp=ti, ot, ab, sh, de, hw, kw, tn, dm, mf, dv, tx, ct, bt, nm, kf, ps, sj, do, po, go, rs, an, ui, dw, pt]
6. limit 5 to english language
7. limit 6 to human
8. limit 7 to yr="2000 -Current"
9. 4 or 8
10. liaison.mp. [mp=ti, ot, ab, sh, de, hw, kw, tn, dm, mf, dv, tx, ct, bt, nm, kf, ps, sj, do, po, go, rs, an, ui, dw, pt]
11. limit 10 to english language
12. limit 11 to yr="2000 -Current"
13. limit 12 to humans
14. 9 and 13
15. evaluation.mp. [mp=ti, ot, ab, sh, de, hw, kw, tn, dm, mf, dv, tx, ct, bt, nm, kf, ps, sj, do, po, go, rs, an, ui, dw, pt]
16. limit 15 to english language
17. limit 16 to yr="2000 -Current"
18. limit 17 to humans
19. 14 and 18
20. remove duplicates from 19



## **Appendix 3**

### **City University**

#### **Department of Mental Health and Learning Disabilities Nursing**

#### **An evaluation of the liaison mental health service at the A & E department of the XXX Hospital**

#### **Sample semi-structured interview guide**

Please describe your experiences of using the liaison mental health service

What do you think are the strengths of this service?

What do you think are the weaknesses of this service?

How do you think this service could be improved?

What impact does this service have on your life/work/?

What makes this service useful to you?

Why do you use this service?

How accessible do you find this service?

Satisfaction with the service overall:

Very	Fairly	Neither satisfied	Slightly	Very
satisfied	satisfied	nor dissatisfied	dissatisfied	dissatisfied



## Appendix 4

### Private & Confidential

1st September 2000

Dear

Re: **Liaison Mental Health Service at the XXX.**

#### **An opportunity to give your comments on the service.**

I am writing to you because you have been seen at the XXX Hospital by a Liaison Mental Health Nurse. You may have been seen when you visited the Accident & Emergency Department or you may have been seen whilst you were on one of the wards.

A research study of the liaison service is underway. The study is funded by the XXX NHS Trust. It is a very important part of the study to ask people who have used the service what they thought about it. You have been chosen at random from all the people who have used the service since April 2000. Hearing what you have to say about the strengths and weaknesses of the service and how the service could be improved is very important to us. The information you give will help the service to improve.

I would like to invite you to attend an interview, the interview will last about 45 minutes. The information you give at the interview will be confidential. The people who work in the liaison service will not know that you have been chosen to have an interview.

The interview will take place at the XXX School of Nursing which is at the back of the main XXX Hospital in Whitechapel. I appreciate that you may have some travel costs and the study has funds to reimburse you up to the value of £3.90. Simply bring your ticket(s) with you and I will photocopy them. If it would not be possible for you to travel to the XXX Hospital we may be able to arrange the interview at a venue more convenient to you.

I will contact you by telephone in the late afternoon of 15th or 18th September to arrange an interview date. If you will not be available then but you would like to be interviewed please contact me on **0207 505 5862**.

Yours sincerely

Sarah Eales

Research Assistant



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## Appendix 5

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1st September 2000

Dear

Re: **Liaison Mental Health Service at the XXX Hospital.**

#### **An opportunity to give your comments on the service.**

I wrote to you recently because you have been seen at the XXX Hospital by a Liaison Mental Health Nurse. You may have been seen when you visited the Accident & Emergency Department or you may have been seen whilst you were on one of the wards.

I invited you to attend an interview to give your views on your experience of the service. I tried to contact you by telephone to arrange a time to come for an interview. Hearing what you have to say about the strengths and weaknesses of the service and how the service could be improved is very important to us. The information you give will help the service to improve.

I have not been able to contact you by telephone, I would therefore like to invite you to attend an interview on:

If you will not be available then but you would like to be interviewed please contact me on **020 7505 5862.**

The interview will take place at the XXX School of Nursing, which is at the back of the XXX Hospital in XXX. I have enclosed a map of how to get to the School of Nursing. Please ask for me at reception.

I look forward to meeting you.

Yours sincerely

Sarah Eales

Research Assistant







# CONTACT DETAILS:

To discuss the project further, to arrange an interview or for a questionnaire please contact:

SARAH EALES (Research Assistant)  
DEPARTMENT OF MENTAL HEALTH  
SCHOOL OF NURSING & MIDWIFERY  
CITY UNIVERSITY  
PHILPOT STREET  
LONDON  
E1 2EA

AN EVALUATION OF THE  
LIAISON MENTAL HEALTH SERVICE  
AT THE  
HOSPITAL

This study is funded by I NHS Trust.

Ethical approval for the study has been granted by  
Research Ethics Committee.  
REC No. P/99/275

This study is being carried out at the moment.

The aim of the study is to evaluate the service offered by the  
Liaison Mental Health Team at the Hospital.

You have been seen by a member of the liaison team and we  
would like to invite you to give feedback on the service you  
received.

## WHAT ARE THE AIMS OF THE STUDY?

1. Describe the service offered,
2. Compare this service with services in other hospitals in London.
3. Investigate stakeholders', including service users' views of the service provided.
4. Measure service users' satisfaction with the service provided.
5. Provide a basis for future clinical studies of different forms of intervention.

## WHY SHOULD I BOTHER JOINING IN?

- The more people that join the study the more confident we can be that the feedback we give to the liaison team is representative of all the people they see.
- We are interested in all types of experience both satisfied and dissatisfied. The team need to know what they do that helps people as much as things they need to change.
- The information you give the researcher will be confidential. Your name will not be used at all when we use the results of the study.

## HOW CAN I BE INVOLVED IN THE STUDY?

Meet the researcher for an interview:

- The researcher (Sarah Eales) would be very interested to get your opinion about the visit you have just received.
- Sarah would like to know what you found useful about the service you received and also how the service could be improved.
- If you contact Sarah she can discuss your role in the research in more detail.

Complete a questionnaire:

- The researcher will be sending a questionnaire to everyone in the new year. Please fill it out and return it in the pre-paid envelope.
- If you do not receive one you can contact the researcher and she will post one to you, or arrange for you to pick it up.

## OTHER USEFUL INFORMATION?

- The interview can take place:
  - In a quiet place on the ward.
  - On the ... site.
  - At your home.
- The researcher can reimburse any travel expenses for coming to the interview.
- If you participate in an interview you will receive a £5 voucher.

## **Appendix 7**

### **An evaluation of the liaison mental health service at the Casualty department of the XXX Hospital**

#### **XXX HEALTH AUTHORITY**

##### **Invitation to participate and study information sheet for patients**

We invite you to take part in a research study that we think may be important. The information that follows tells you about it. It is important that you understand what is in this leaflet. It says what will happen if you take part and what the risks might be. Try to make sure you know what will happen to you if you decide to take part. Whether or not you do take part is entirely your choice. Please ask any questions you want to about the research and we will try our best to answer them. You do not have to join the study. You are free to decide not to be in this study or to drop out at any time. If you decide not to be in the study, or drop out, this will not put at risk your treatment.

You have been identified to participate in this research because you have recently used the liaison mental health service at the Casualty department of the XXX Hospital and we would like you to give us your views about the service you received..

The goal of the study is to describe and evaluate the liaison mental health service. To do this we would like you to complete a questionnaire measuring your satisfaction with the service you received. We may also invite you to be interviewed at a later date at your convenience to discuss with you your views about the service you received. We will tape record this interview. The interview will last about 45 minutes.

We will not identify you in any data that we collect from you. Only members of the research team will have access to the data you provide. We may quote in research papers some things that you say during the study, but we will not identify you in any way. If you agree to take part we will ask you to sign a consent form so that it is clear from our records that you agreed to take part.

Our researcher is happy to answer any questions about the study and your involvement before you decide to take part.

We will take every care in the course of this study. If through our negligence any harm to you results, you will be compensated. However, a claim may have to be pursued through legal action. Even if the harm is not our fault, the University will consider any claim sympathetically. If you are not happy with any proposed compensation you may have to pursue your claim through legal action.



## Appendix 8

### **WRITTEN CONSENT FORM:**

#### **Title of research proposal:**

**An evaluation of the liaison mental health service at the XXX Hospital**

**REC Number:** P/99/275

**Name of Patient** (Block Capitals): .....

**Address:**.....

- The study organisers have invited me to take part in this research. .... [ ]
- I understand what is in the leaflet about the research. I have a copy of the leaflet to keep. .... [ ]
- I have had the chance to talk and ask questions about the study..... [ ]
- I know what my part will be in the study and I know how long it will take. .... [ ]
- I have been told about any special drugs, operations, tests or other checks I might be given. .... n/a
- I know how the study may affect me. I have been told if there are possible risks. .... [ ]
- I understand that I should not take part in more than one study at a time..... [ ]
- I know that the local xxx Health Authority Research Ethics Committee has seen and agreed to this study. .... [ ]
- I understand that personal information is strictly confidential: I know the only people who may see information about my part in the study are the research team or an official representative of the organisation which funded the research..... [ ]
- I know that the researchers will/might tell my general practitioner (GP) about my part in the study. .... [ ]
- I freely consent to be a subject in the study. No-one has put pressure on me..... [ ]
- I know that I can stop taking part in the study at any time..... [ ]
- I know if I do not take part I will still be able to have my normal treatment..... [ ]
- I know that if there are any problems, I can contact:

Mr Patrick Callaghan - 020 7505 5890

Ms Sarah Eales - 020 7505 5862

Patient's: Signature .....

Witness's Name .....

Witness's Signature: .....

Date .....

The following should be signed by the Clinician/Investigator responsible for obtaining consent

As the Clinician/Investigator responsible for this research or a designated deputy, I confirm that I have explained to the patient/volunteer named above the nature and purpose of the research to be undertaken.

Investigators Name: Sarah Eales

Investigators Signature: ..... Date: .....

Clinician's Name: Mr TJ Coates

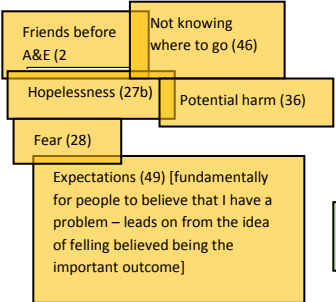
Clinician's Signature: ..... Date: .....



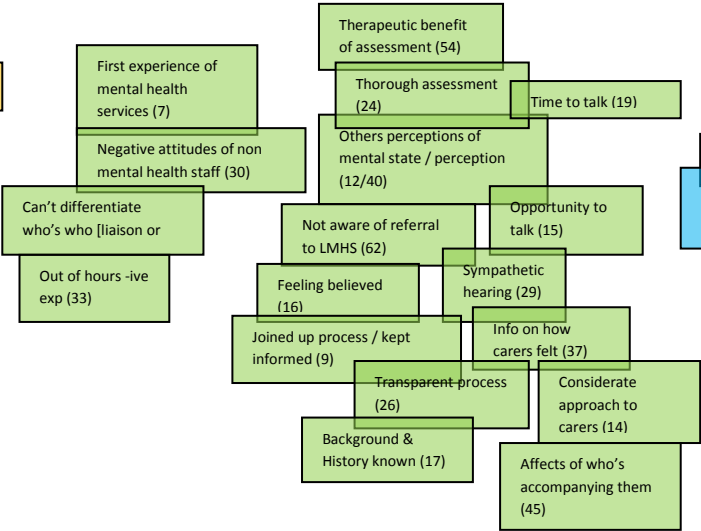


Negotiating / navigating the system (42)

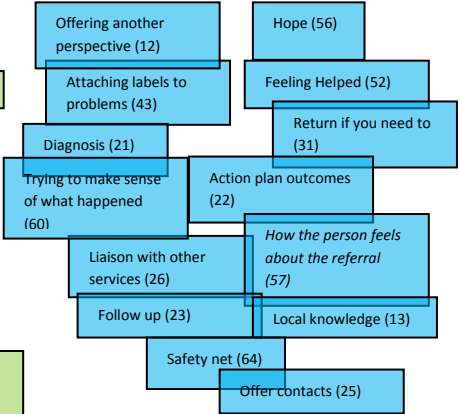
Pre-contact: build-up of an unresolved



Into A&E & LMHS

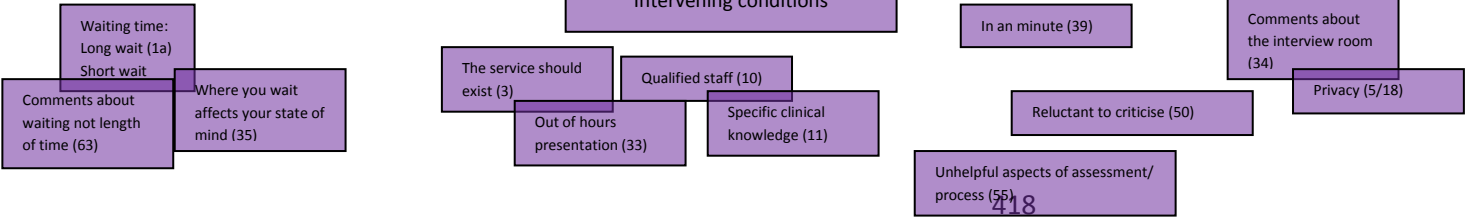


Outcomes



Safety Net (64)  
Potential Harm (36)  
Prevention what could have been if things had gone right (44)

Intervening conditions



Appendix 9



## Appendix 10

### Appendix ##

#### Opportunity to talk memo

LOG: 11:51 am, 8/9/06. : Merged with Copy of node (5 3). "Time to talk" (1 Node)

Description: Copy of node (5 3).

**Comment [ES1]:** Two codes "time to talk" & "opportunity to talk" are merged

LOG: 11:50 am, 8/9/06. : Copy of node (5 3) .

22-05-07: Iv 49 gives an example of a negative experience where he isn't offered the opportunity to talk on his first visit.

LOG: 3:57 pm, 7/28/10. : Copy of node (4 6) .

LOG: 3:58 pm, 7/28/10. : Merged with Copy of node (5 3). "Time to talk" (1 Node)  
Description: Copy of node (5 3).

21-05-07: Is the opportunity to talk as expressed in Iv 49 44-47 an expectation?

24-05-07: Iv 23 perceives clock watching and doesn't like this, is the nurse trying to communicate a limit to the time to talk.

24-05-07: the example above from Iv23 seems to legitimise this code which I was wondering why existed as it seemed to incorporate much of the opportunity to talk node

**Comment [ES2]:** The researcher identifies a data fragment which seems to legitimise the "time to talk" code, however this does not develop and the codes remain merged. Clock watching becomes a dimension of the category.

LOG: 3:57 pm, 7/28/10. : Copy of node (5 3) .

27-07-10: the log above shows this but I have combined two codes opportunity to talk and time to talk to give a single code opportunity to talk, there is too little variance to justify both codes.

#### 28-07-10 Summary

What is the experience of the LMHS?

A key aspect of the experience is the opportunity to talk (Iv19.). Some people are aware that this is a service offered by LMHS and seek out the service specifically for that purpose. In the case of in-patient interactions this can be about wanting to continue a dialogue that has begun with an initial assessment (Iv19.). Others are surprised that it is an option especially in A&E. The desire to be allowed to tell their story is very strong for some service users. There are those that find that talking to the more anonymous and unknown LMHS staff allows them to open up in a way that they cannot open up to their friends and family. For another service user it is the facilitation or bringing together of the service user and their significant other to talk in a safe environment that really helps their situation. When the opportunity to talk is not there, is brief (Iv19.) or seems forced - e.g. clock watching then the service user finds the experience more negative.

**Comment [ES3]:** A summary is created to help the researcher consider the properties and dimensions of the category. The summary focuses on the research question and how this category helps to answer that question.

There is a link here to potential harm, the opportunity to talk can prevent further harm.

I am stuck by this being at the heart of the therapeutic nature of the interaction with the LMHS.

**Comment [ES4]:** Links to other categories are noted

[Type text]

## Appendix 11

### Author publications in the field of Liaison Mental Health Care:

Over the course of the study the author has published two articles related to LMHC:

Eales, S, Callaghan, P, & Johnson, B (2006) Service Users and other stakeholders' evaluation of a liaison mental health service in an accident and emergency department and a general hospital setting. *Journal of Psychiatric & Mental Health Nursing*, 13, 70-71.

Callaghan, P., Eales, S., Coats, T. & Bowers, L. (2003) A review of research on the structure, process and outcome of liaison mental health services. *Journal of Psychiatric & Mental Health Nursing*, 10, 155-165.

Two publications on the topic of LMHC predate the beginning of this study:

Callaghan, P., Eales, S., Coats, T., Bowers, L. & Bunker, J. (2002) Patient feedback on liaison mental health care. *Nursing Times*, 98(21), 34-36.

Callaghan, P., Eales, S., Leigh, L., Smith, A. & Nichols, J. (2001) Characteristics of an Accident and Emergency liaison mental health service in East London. *Journal of Advanced Nursing* 35(6), 812-818.

One book chapter has also been written:

Eales, S. (2006) Liaison Mental Health Services. In Callaghan, P. & Waldock, H. (eds) *Oxford Handbook of Mental Health Nursing*. Oxford University Press, Oxford, UK

Publications from the Haemodialysis Unit Study:

Ross, J., Jones, J., Callaghan, P., Eales, S. & Ashman, N. (2009) A survey of stress, job satisfaction and burnout among haemodialysis staff. *Journal of Renal Care*, 35 (3) 127-133

Jones, J., Ridge, G., Eales, S., Ashman, N. & Callaghan, P. (2008) Violence and aggression on haemodialysis units. *British Journal of Renal Medicine*, 13 (1) 8-9.

